GUY'S HOSPITAL GAZETTE 1ST SERIES VOL 8 1873-74

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Guy's Hospital Gazette.

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GUY'S HOSPITAL MEDICAL SCHOOL

Presented by the Presidents of the Physical Society

March 1878

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Guy's

Hospital Gazette.

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VOL. III.—NO. 1. SATURDAY, OCTOBER 4, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ON Wednesday last the Past and Present Students of the Hospital met in the Anatomical Theatre, to give, through the happy medium of Mr. Hinton, a hearty, though formal, welcome to those who are about to become fellow-workers and fellow-students. Fatherly aphorisms and sententious truisms, admitted axioms, and terribly trite truths will have been spoken elsewhere on Wednesday, echoing to the end of the week amidst the columns of the daily and weekly press. But see, with what result? Fatigue and unprofitableness. We think that if the introducer of the Session, as in the case of our own school, would oftener vary from the beaten and monotonous turnpike of advice, into the byway of entertaining philosophy, there would be, as year after year established the custom, less fear of mistimed jokes and less need of the newly organised force of professional police. We are of opinion that had all Mr. Hinton's words been heard, and the easy and natural expression of his most original ideas been unbroken by the usual interruption of paper and crackers, his address would scarcely have been less interesting than instructive. We have read that man is never so powerful and so loved a teacher as when descending from the pinnacle of authority he learns with, and leads his pupil, instead of letting down a very long rope, by which he may raise himself. Mr. Hinton, on Wednesday, showed us, that it is by Nature manifesting herself to us in her simplest forms, that we shall probably be able to climb with her to her grandest heights. This is the way in which we, the students of Guy's, are taught, for by the words of the speaker, at the opening of the present Session, we have confirmation of what was said about a year ago, that our lecturers consider themselves still students, but students of a larger growth. The man who begins at the beginning, and tells us the thoughts and processes of his own brain, which lead him to some definite and demonstrable conclusion, will be a more influential teacher than he who simply gives the conclusions themselves in the form of dogma. The same holds good with ourselves. A fact learnt from a text book, like a parrot, is dry and uninteresting compared with a fact to which we have climbed and gained by logical deduction. We thank Mr. Hinton that he has taught us this,—that if we wish to study the natural, we must begin at the first step and make that firm, letting each subsequent step be true and simple, or our progress will be false and digressive. Simple; not being enticed into the sweetness of abstruseness. It is said that when Nature desires to keep one for the purpose of reading and interpreting "the manuscripts of God," she "keeps him still a child." Let, us, then be simple, whether it be in making our diagnoses or in unravelling pathological processes, and the greater probability is, that Truth will then be on on our side.

THE commencement of another Winter Session naturally leads us to consider the position of our Physical Society—one of the most pleasant, if not most important, features in the school department of our Hospital. We are especially led to do so just now, in order that it may be at once brought before the notice of all the new men entering our walls. On Wednesday they were welcomed as Guy's men; already are they working side by side with us, and, having manfully tackled their duties, we heartily recommend them not to neglect their privileges, but to take the first opportunity of becoming members of the Physical Society; for which opportunity, thanks to the zeal of our Presidents, they will not have to wait long, after they have decided to pay their five shillings' subscription towards making up the prizes, for which they themselves can compete.

If any hesitate to subscribe at once, we would advise them to attend this evening's meeting as a friend of one who has already become a member, and we are sure that, when they hear our Hon. President—Mr. Cock—in his address this evening tell us, as he has told for years, of the interest he has always taken in this society, of the love he bears it, how he has watched it and cared for it from its birth until it has grown up to be the most flourishing of Pupils' Physical Societies; and then, if they only hear him, as we have heard him, speaking of its glories, with the powerful energy, the burning enthusiasm, the stirring emotion of his great and noble love for it, of which the flame burns ever young within him; telling of the many great men which were nurtured in its bosom, and date their illustrious careers from the time that they were admitted as members, and urging us to take example from such, and to remember that—

Lives of great men all remind us,
We may make our lives sublime,
And, departing, leave behind us
Footprints on the sands of time.

We say we are sure that none would longer hesitate, but rather count it an honour, if they only gained by becoming members of Guy's Physical Society, a share of its President's honest affection. But we had proposed to consider the position of the Physical Society, when we were led away by our desire to add to its members. Last year was without doubt very successful, but this must be more so; the present fourth year, of which the men should take the most active part in the meetings, is the largest yet known at any London Hospital, perhaps the largest we may ever have; and here we are reminded again of Mr. Cock; he describes the members of the Physical Society as a stream constantly runnng past him—old faces ever rushing on into the sea of life beyond, new ones ever gathering from a thousand sources; since the birth of our Society this is the largest stream he has ever watched, as it rolled past him. May he have cause to remember it, not by its size, but by its energy.

ELECTROLYTIC TREATMENT OF ULCERS.

By C. H. GOLDING BIRD.

Since communicating some notes and cases on this subject a short time back to the *Gazette* (May—June, 1873), more extended clinical and experimental observations have elucidated facts which may not be found uninteresting.

An experiment by Dr. Babington, many years ago, first led to the use of an electric current for the treatment of ulcers, he having observed that a piece of muscle bound between a silver and zinc plate by a copper wire, underwent certain visible changes, as the result of electro-chemical action, and that putrefaction was delayed; a detailed account of which changes will appear later on.

The application of the plates to new living surfaces produces alterations similar to those observed in the dead, while under suitable circumstances a healing process is set up.

The great objection to the use of the silver and zinc plates directly to the ulcerated surface is the caustic action of the chloride of zinc that is formed, and thus while healing is going on under the former plate, inflammation and rapid destruction of tissue is being caused by the latter. Cases that I treated in this manner, and which I have already reported, showed this point well, while it formed the only material drawback to the more extended application of this principle to the treatment of ulcers. It seemed to me, therefore, that the only way to avoid this would be to pass an electric current from an electromoter outside the body by means of electrodes of some metal that would not be acted on—or at least, not injuriously—by the acids nor bases set free as the result of electro-chemical action.

Electrodes of silver I found to do all that was required in that respect, but the greatest difficulty lay in the construction of a portable battery; for while, as long as the patient kept his bed, a battery at the bedside could well be used, if he came to move about either the treatment must be stopped or a battery that could be carried about with him adopted. In two of the cases to be reported a portable cell was used, but the comparatively short time during which its action continued, and the constant changing required, soon led to its being given up. The difficulties in the construction of a battery for such a purpose are numerous; and cells containing liquid, as dilute sulphuric acid are quite inadmissible, on account of the danger of spilling, though useful in all other respects. The adoption of a cell excited by sand, sewdust, or flannel dipped in acid is prevented by the great internal resistance offered to the current by these substances, which after the first few minutes considerably weakens, and later on all but stops the passage of any electric current at all; and though the multiplication of elements would overcome this the consequent weight and bulk put a limit upon the number used. In two cases, however, I used a battery excited by lint moistened with a solution of common salt in water, but it required changing every morning; in the last case reported, as the patient remained perfectly quiet, the battery was fastened to the head of the bed, and the silver plates on the ulcer were connected to it by copper-wires.

The portable battery consisted of a slip of thin zinc, 2in. by 1in., amalgamated with mercury, with a copper-wire soldered to one end, and a piece of silver foil rather shorter but of nearly twice the breadth, also with a wire, folded to

clasp the zinc like the cover of a book, the two metals being separated from one another by a layer of lint dipped in salt and water; lint moistened in the same way was also wrapped outside, the whole being dropped into a cell of gutta percha tissue, which was afterwards hermetically sealed at the top and at the points at which the electrodes issued. The reason for using salt and not dilute sulphuric acid is that the latter gives rise to the evolution of a large quantity of hydrogen gas that would burst in a short time the impervious cell.

The battery used in the third case was of the same size and material as the last, but the two metals were isolated by a slip of gutta percha placed between them instead of lint dipped in salt and water. They were acted on by a very dilute solution of sulphuric acid, placed in an open cell of ordinary sheet-guttapercha of about one ounce capacity. The advantage of this form of cell over the other is great. The current developed is more intense, the internal resistance is reduced to a minimum, it continues longer in action, and when necessary the plates can be much more easily cleaned or changed. A rough estimation of the intensity of the current can be gathered from the fact, that three cells of the size stated in combination will decompose water and work effectually a galvanic coil of the size ordinarily used in the wards; such a combination is, however, too strong when in good working order for clinical purposes, for it both gives rise to a severe burning pain, and rapidly destroys the negative silver electrode; usually one cell is sufficient.

The solution of the negative electrode is simply the result of electro-chemical action, and only impedes the therapentic action of the current when its disconnection with the copper wire from the battery is complete. The *rationale* of its destruction is simply that while chlorine is developed under the positive plate, sodium (derived from the serum) is formed under the negative one, and uniting with the silver as an amalgam, reduces the latter to an impalpable powder on the surface of the ulcer. This action of the electrolyte upon the electrode is not without its advantages; for if in decomposing a fluid by an electric current, electrodes be used, for neither of which the components of the electrolyte have any affinity, there will be either no action at all, or a much more powerful current must be used. It follows from this that different results may be obtained according as varying electrodes are employed, and hence various modifications of the healing process produced. In order to investigate some of these results upon animal structures, I performed one or two experiments with electrodes of different metals: but on living tissues as yet only the silver electrodes have been employed.

(*To be Continued.*)

CORRESPONDENCE

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[*We do not hold ourselves responsible for the opinions expressed by our Correspondents*]

To the Editor.

Sir,—Perhaps the following case may interest some of you readers:—

Mrs. T., æt. 63, married, and mother of several children. About *fifteen years* ago patient first observed a tumour at the navel, about the size of a small apple, which apparently came suddenly, and gradually increased in size until it attained its present dimensions; she has occasionally had great pain in it, with a very unpleasant gurgling, accompanied with much rising of wind. Does not remember vomiting much.

When first seen, June 30th, 1873.—Patient is a very stout woman; she complains of great pain in her abdomen, bowels very constipated, does not vomit. Has a tumour measuring 21 inches in width and 33 inches in length; resonant at the upper surface, duller at the lower, no wave thrill to be felt, a very loud gurgling is felt and heard, which gives the sensation of moving fluid. The tumour is "puckered in" at the centre; there is evidently almost all the bowel outside abdomen. Patient is very weak, tongue clear, pulse weak 70. To have Mist. Ferri Perchl 1 oz. t. d. s.; Pulv. Jalapæ. Co. 20 gr. stat m ex aqua.

July 1.—Bowels acting tolerably well.

July 7.—Complains of great pain in abdomen; is unable to sleep at night. To have Pil. Morhpiæ ½ gr. p. r. n.

July 9.—Has repeatedly vomited stercoraceously and suffers extreme pain in abdomen, is unable to micturate, so catheter was passed and urine drawn off. Tongue brownish, pulse weak 130. To have Mist. Effervesc. 1 oz., Tr. Opii. 10 m., Acidi Hydrocyanici Dil. 2 m. p. r. n., Pil. Opii 1 gr. every 4 hours, not to be taken at the same time as the mixture.

July 12.—The vomiting ceased yesterday, the bowels are acting well, micturates freely, pulse 100.

July 13.—Has diarrhœa, pulse 100 very weak.

July 14.—Feels better, but is very weak and thirsty, tongue brownish, dry, pulse the same, vomits a little. To have Mist. Effervesc. 1 oz., Tr. Calumbœ 1 gr. every 4 hours, Pulv. Opii 1 gr., Quinœ Sulph. 1 gr. in pil every four hours.

July 18.—She says the pills appear to relieve her pain and support her. has had constant diarrhœa for the last few days. To have Mist. Hamatoxyli 1 oz. p. r. n.

July 20—Is improving daily, diarrhœa has ceased.

August 5—Is now able to get up.

September 10—Gets up and does a little household work, and is able to walk out a short distance. Tumour remains the same.

Remarks.—The tumour is undoubtedly an umbilical hernia, (and is the largest I ever saw), I suppose the probability is that the bowel was strangulated and afterwards released.

I remain,

Your obedient Servant,

Wm. Hy. Spurgin.

York, Sept. 23, 1873.

The Voluntary Entrance Examination has been postponed from the 6th inst., to the 9th inst.

MEDICAL WARDS.

—o—

We are indebted to Mr. Richardson for the following report of a case of

PLEURO-PNEUMONIA.

M. M., æt. 33, was admitted into No. 4, Stephen Ward, on September 22, 1873.

Patient, who is a carman, and has been exposed to draughts for this last week, states that last Thursday a numbness came over him On Friday his appetite began to go, after Friday night never touched anything, began to cough on Friday and spit up a lot of phlegm on Friday night, took some Ol. Ricini. On Saturday went to a doctor. Came to the hospital this morning, and was taken in. Was very bad all last night, and could scarcely walk this morning.

On Admission.—Patient is a dark man, with a hectic flush and hacking cough; tongue over centre is covered with a thick yellowish-white fur purple at margins, and red at sides and tip, skin burning hot and dry, appetite bad, very thirsty, complains of nausea, bowels regular, sputa rusty, spits a good deal, lungs resonant in front. On examination behind there is pretty good resonance on both sides, until you get to a line level with superior angle of scapula, when there is no resonance to base on left side. Bronchial breathing at left base. Œgophony heard over inferior three or four ribs; above this there is bronchophony; tubular breathing above inferior angle of scapula well marked. Pleuritic rub to be heard on left side about 2 in. below scapula. Slight loss of tactile vibration at left base. Right lung—expiratory movement increased; both sides expand well. Pulse, morning 132, evening 100. Temp. morning 104, evening 102·5. Resp. morning 36, evening 36. Ordered Vin. Antimonialis 5 m., ex Mist. Ammon Acet. 1 oz. every four hours. Diet—Milk and beef tea Cataplasma Lini appl.

September 23—Tongue furred at centre, red at tip and sides, subsultus tendinum, alæ nasi working, lips flushed. Is delirius, and is obliged to be strapped down. Coun tenance flushed, eyes very bright and glaring
Ordered Mist. Vinum Gallici 1 oz. p. r. n., Chloral Hyd. 30 grs., Syrupi Limonis 1 dr.. Aqua 1 oz. p. r. n., Brandy 4 oz. Temp.. morning 104·4, evening 101·9. Pulse, morning 132, evening 150. Resp., morning 40, evening 42.

September 24 -Temp. 104·9 morning. Pulse uncountable. Resp. 48. Bad night, noisy delirium until six this morning, when he appeared to be exhausted; since then has been muttering; straps taken off; takes plenty of nourishment; pupils very c ntracted; perspiring freely. Ordered Ol. Terebri statim. 12.30 p.m.—Venesection was performed by the House Physician by opening the basilic vein, when 4 oz. of blood was taken away. Temp. 105·8. Pulse 120. Blue lips. Ordered Ammon. Carb. 5 grs., Vin Ipecac. 20 m., Tinct. Camph. Co. 1 dr., Aqua Camph. 1 oz. statim. 1 p.m.—dead.

The following cases were admitted from Sept. 20 to Sept. 27, 1873.

PETERSHAM.

7—Dropsy—Albuminuria
16—Diabetes
20—Continued Fever ?

PHILIP.

5—Rheumatism
8—Partial Pasaplegia
11—Aortic Rheumatism
13—Fever
29—Cardiac Disease after Rheumatism—Partial Paralysis
33—Obstruction of Iliac Vein—Enlarged Glands?
43—Aortic Regurgitant—Bronchitis—Emphysema
49—Erythema

STEPHEN

19—Morbus Brightii
25—Hemiplegia, left
28—Continued Fever
33—Typhoid Fever
38—Tumour (?) in Abdomen
46—Rheumatic Gout
50—Albuminuria

MARY.

19—Mental ?
23—Chorea

ADDISON.

No new Cases.

JOHN (Clinical).

5—Typhoid
11—Rheumatic Fever
14—Morbus Cordis

MIRIAM (Clinical).

25—Cerebral (?)

SURGICAL WARDS.

—o—

The following cases were admitted from Sept. 21 to Sept. 27, 1873.

ACCIDENT.

13—Concussion of Spine—Death
13—Injury to Back
14—Fracture of Fibula
18—Fracture of Fibula
19—Fracture of Base
27—Fracture of Tibia and Fibula
29—Fracture of Femur

CORNELIUS.

4—Fractured Base
10—Fractured Base
15—Compound Fractured Femur—Dead
16—Crushed Toes
20—Fractured Leg

MARTHA.

7—Diseased Hip
14—Amputation of Breast
16—Ulcerated Leg

JOB.

2—Fractured Patella
4—Kick from Horse on Tibia
6—Osteo-arthritis
8—Cut Ulna, Artery and Nerve
14—Fistula in Ano
20—Epithelioma of Penis

LAZARUS.

No new Cases.

NAAMAN.

3—Runover—Death
3—Necrosis of R. Humerus
3½—Diseased Bone of Arm
4—Ulcer of Leg
11—Throat Disease
13—Stricture
15—Enlarged Glands of Throat
20—Injury to Ankle
21—Rupture

LUKE.

No new Cases.

CHARITY.

4—Removal of Vascular Growth

DORCAS.

5—Bursa Patella
10—Synovitis of Knee
12—Necrosis of Tibia
13—Injury to Knee
16—Hare Lip
17—Abscess of Face and Arm
20—Carcinoma of Breast
21—Ulceration of Foot and Leg

LYDIA

No new Cases.

BARNABAS (Ophthalmic.)

4—Old Granular Lids—Opacity of Cornea
10—Iridectomy
17—Cataract of L. Eye
20—Cataract
23—Glaucoma
24—Cataract

RUTH (Ophthalmic).

3—Cataract
5—Cataract
6—Glaucoma
10—Injury to Eyeball
25—Cataract

EXTRACTS.

—o—

(*From the Medical Press.*)

Cure of Aortic Aneurism by the "Rest" Treatment.—A very interesting and important case has recently been brought to the test of direct observation in Dublin, in which, after the complete failure of other methods of treatment, the efficacy of the "rest" treatment in aortic aneurism has been proved. The patient had been transferred from Liverpool to the City of Dublin Hospital in last January, and placed under the care of Mr. Joliffe Tufnel, who adopted the method of perfect rest in the recumbent posture, as recommended in his work on Aneurism. After the man had —apparently—completely recovered, he was attacked by Bright's disease, which carried him off last week. The autopsy revealed the cause of death well-marked in the kidney. The cure of the aortic disease was beautifully illustrated, the entire anuerismal sac, saving a small passage for the blood in its natural course, being consolidated in successive union, like layers of fibrin. The vertebra or spinal column were not at all affected, and the normal condition of the branching arteries was maintained.

Nelaton.—The following anecdote respecting Nelaton has recently appeared in the foreign journals. As is well known, Nelaton was the favourite pupil of Dupuytren, surgeon at the Hotel Dieu. Dupuytren had made numerous enemies, amongst whom was Lisfranc of La Pitie. One day Dupuytren required a delicate instrument for the operation for cataract, which was not to be found at the Hotel Dieu, and sent Nelaton to borrow it of his rival. Lisfranc refused point-blank, at the same time remarking that clever people should not need to borrow from others, Nelaton was very sensitive to blame, and dared not carry this message back to his master, whose brusque temper was proverbial, so he ran to Charriere, the instrument-maker, and ordered the instrument to be made at his own expense, from his description, at the same time introducing an ingenious modification which seemed to him to insure the success of the operation. It was ready on the next day, and was sent as from La Pitie. The operation was a brilliant success, and Dupuytren was so pleased with the instrument, which he thought to be Lisfranc's, that he immediately ordered one like it to be made for the Hotel Dieu. Nelaton then revealed his secret, to the delight and admiration of his master.

Aneurismal Varix of the Femoral Vessels.—At the Hotel Dieu a remarkable instance of this affection has lately been under observation. A man in catching at a scraper falling from a height missed it and endeavoured to stop it by closing on it with his knees. The instrument cut down into the femoral artery. The wound was closed directly by himself and wife, and in two days after, when presenting himself at hospital, the symptoms of a varix were marked. A tumour with impulse and a well-marked thrill, were sufficiently indicative of the affection. Digital pressure was applied for ten hours without permanent result; in a few days after the pressure was reapplied, which was maintained for eleven hours. The patient, however, obtained perfect use of the limb by using a light elastic web pressure around it. The aneurismal symptoms continued.

Hysteria Occurring where the Uterus and Ovaries were Absent.—Dr. Puech has lately observed the case of a woman who suffered from most characteristic hysterical fits, in whom the ovaries and uterus were absent. Each month there had been attempts at menstrual molimen, but no external appearances whatever. Four instances of similar phenomena have now been recorded by Negrier, Leudet, Castiaux, and this one—going to prove that irritation of the uterus may have nothing to say to hysterical affections.

Teratment of Cancer of the Breast.—M. Roubeix uses the following as an aid in treatment of cancer of the breast, at the Hospital St. Jean :—He removes the breast as

usual, and then applies over the wound a thin layer of Cangnoin's paste spread on linen. The thorough extirpation of the diseased part is thus attained with little pain, and the avoidance of any secondary hæmorrhage, the wound healing like an ordinary cauterised wound.

TREATMENT OF CHRONIC CATARRH OF THE PHARYNX BY GALVANO-CAUTERY.—Dr. Carl Michel recommends in this troublesome affection the direct application of galvano-cautery, by means of a battery of Medeldorpff. In seventy cases he obtained a cure, notwithstanding the failure of inhalations and other means which had been previously attempted.

THE late Dr. Nelaton was buried on Sept. 21 at Pere-la-Chaise, in consonance with his wishes, without pomp; but a large Medical concourse accompanied his funeral The pall, as a graceful compliment, was borne by representatives of the learned bodies—M. Bouillard for the Institute; M. Depaul for the Academy; M. Bouchardat for the Faculty of Medicine; and M. Beclard for the Medical Association of the Seine.

(From the Medical Record.)

PROFESSOR CZERMAK, to whom Medicine is principally indebted for the introduction of the laryngoscope into practice, has recently died in Leipzig of diabetes, at the age of forty-five. He was a native of Prague. He held in succession the posts of professor of zoology in Cracow and Pesth, director of the physiological institute in Prague, and professor of physiology in Jena (1865) and Leipzig (1869).

GENERAL NEWS.

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APPOINTMENTS FOR OCTOBER, 1873.

House Physicians—
Mr. Ticehurst and Dr. Galabin.

Junior House Physician—
Mr. R. J. Pye-Smith.

House Surgeon—
Mr. Eastes.

Junior House Surgeon—
Mr. J. A. Morley.

Senior Obstetric Assistant—
Mr. Power.

Junior Obstetric Assistant—
Mr S. Duke.

J. C. STEELE,
Superintendent.

Guy's Hospital,
October 1, 1873.

Royal College of Surgeons of England.
Examination for Membership, November, 1873.

Special Demonstrations in Practical Surgery for the above Examination will be given as usual by Mr. Rendle, in the Class Room adjoining the Library, on Mondays, Wednesdays, and Fridays, at 7.30 p.m., commencing on Monday, October 6th.

Physical Society.

The Society will meet this Evening at 7,30, Mr. Cock presiding, when Mr. Lubbock will read a paper on "Retention of Urine."

Fred. Taylor, Hon. Sec.

The Class of Practical Physiology (for names with initials A to M) will be given on Thursday, October 9th, at 1.30.

EDITORIAL NOTICES.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Special arrangements may be made for a series of insertion.

Gentlemen who have sent us Subscriptions from the country will kindly consider the receipt of the "Gazette" to be sufficient acknowledgment for the same.

A RED CROSS on the wrapper means that the subscription is due.

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The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.
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The lithographed edition of Mr. C.'s Analytical and Synoptical Tablet now embraces nearly the whole of Anatomy and Physiology, and Special Tables on Comparative Anatomy and Development for the F.R.S.C Examinations are in course of preparation For the printed Tablets see above.

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Guy's

Hospital Gazette.

VOL. III.—NO. 2. SATURDAY, OCTOBER 11, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

AT this season of advice we are glad to observe that our able contemporary, the *Lancet*, by a knowledge of Hospital education, has omitted to give sage counsel where it cannot be appreciated—to those who have but very little choice, except to do as they are told, but upon whom a great many pages have been expended during the past week. So many seem to forget that, in these times, a student *must* learn his bones, he *must* dissect, he *must* use his microscope, he *must* attend his Anatomy and Physiology Lectures; all this is provided for. There are two distinct sections in the student's course at a hospital; the first, comprising anatomy, physiology, and their various branch studies. These he is told to do; there is a Janitor to see that he does them, and, recently at most large hospitals, there is also a Demonstrator to test whether he has done them to sufficient advantage, before he is allowed to present himself at the College for examination. The second section comprises, mainly, the Clinical teaching, and extends usually over three summer and two winter sessions, of which only three months' clinical assistant, and six months' dressing are definitely insisted on. The student pleases himself as to his visits to the wards, the out-patient rooms, the post-mortem room, tho diseases of women, and so on; he is, in fact, completely independent in his studies; at liberty, if he do not choose to work, to bring discredit on his hospital by his repeated failures at his examinations. The *Lancet*, we say, having observed these distinctions in the student's course, has been enabled to apply its advice, where it has a chance of being appreciated, which, in the main comes to this, that the *must* learn should be applied to clinical studies as strongly as to the anatomical or physiological.

It is undoubtedly very good that every student should be forced to lay a firm foundation of anatomy and physiology, upon which to build his professional education; but we agree with the *Lancet*, that a little of the wholesome care, expended in making him lay a good foundation, might, with advantage, be observed to require that he shall raise a worthy structure on it. This would in no wise interfere with even the mass of students; as a whole, they work excellently in the wards, and are only too glad to attend all good clinical classes; we are quite sure that no physician or surgeon at Guy's is ever more ready to form a clinical class than are a number of students to join it. But, at the same time, there are a number more—those who most require it—who never go near such a class; it is only such that would be inconvenienced by being forced to attend, or intimidated by a test similar to that which is applied to the men before going up to their First College.

WE are glad to observe by the Notice Board that the idea of forming a "Guyite Club" from the men who entered in the Sessions of 1869-70 and 1870-71 is gradually ripening into a reality. To us the social, the jovial, the time-honoured custom of the yearly *réunion* at dinner seems to us one of the brightest prospects at parting from the happy student-times; we shall always look forward to it as

"The happiest day (or night) of all the glad new year."

It will be remembered that the first proceedings of the proposed club were reported in these columns some time since, when Messrs. Chicken, Paul, McKay, Metcalf, Rudd and Hooper were appointed members of a temporary committee, of which the chief function was to obtain the names of those who wished to join; we hope that they will have a long list to propose as members at the next general meeting. We heartily wish the "Proposed Guyite Club" of the present fourth and fifth year's men every possible success.

It will be observed, in another column further on, that we have resumed our Note Book; and we have done so because we believe these jewels of knowledge, dropped by learned men, will be well appreciated by our readers, for whom we pick them up, when we tell them that, owing to an improved system, we have, we believe, been enabled to overcome the difficulty, which led us to suppress their publication—that difficulty our readers are acquainted with. It must be borne in mind that each note is not a summary of general opinion, but the teaching of one man, that man, however, in all cases, one of the bright lights of the Profession.

Up to the present time the entries of new men at Guy's number 92; we cannot for certainty speak of the exact number at other Hospitals, but rumour says that Guy's heads the list. We have it on good authority, that St. Thomas's has only entered 80 new men, and Bartholomew's only one or two more; of University, we are sorry to have heard nothing yet, since it having tied us last year, we are sure that our readers are anxious to hear their number of entries.

ORIGINAL COMMUNICATIONS.

—o—

ELECTROLYTIC TREATMENT OF ULCERS.

By C. H. Golding Bird.

(*Continued from Page 3.*)

The observations were made upon fresh muscular tissue, at an average temperature of 65° F., and each experiment was continued for 24 hours. The pieces of flesh were placed between the several electrodes, and kept moist either by a piece of lint dipped in water being wrapped round each, or by being enclosed in gutta percha.

The electromotor used was one cell of the sulphuric acid battery, before described, for each experiment. The different metals employed were soldered to copper wire electrodes for in using a battery of low intensity especially, it makes a great difference whether the connections be soldered, or simply twisted or clamped. If soldered, perfect "continuity of tissue" is ensured, and if not a perceptible amount of resistance is sure to be experienced.

Exp. A.—Flesh enclosed between a plate of zinc (positive electrode) and one of silver (negative electrode). On removal, the surface in contact with the silver was moist, rather gelatinous-looking, harder than normal (a piece of muscle having been kept untouched for comparison), of usual color, and *strongly alkaline* to test paper. The fresh muscle was also alkaline.

The surface in contact with the zinc was shrivelled, though moist, white, hard, fibrous-looking, adhering firmly to the plate from which it had to be broken, and to which some remained fixed. The white color and brittle hardness extended about $\frac{1}{8}$th inch into the substance of the muscle, but throughout it was, as stated above, harder than normal—*strongly acid* to test paper.

Exp. B.—Flesh enclosed between two plates of silver foil. On removal of the negative electrode (*i.e.* the one connected with the zinc plate of the battery) the surface was paler, softer, and more decomposed than under silver plate in Exp. A.; was soft, oozing and not gelatinous, but the piece of flesh as a whole, was firmer than the piece kept unacted upon for comparison. The surface was strongly acid.

Beneath the positive electrode, the surface, which was rather adherent to the plate, was covered with extremely thin and papery flakes, whitish towards the flesh to which they were firmly fixed, and black towards the silver plate; very brittle and friable, and could only be removed by cutting off a piece of flesh with them. The plate was covered with opaque white patches as though daubed with white paint, which could not to be detached. The surface was firmer than under the other electrode, and was strongly alkaline.

The piece of flesh kept for comparison and under the same conditions as regards moisture and temperature, was rather softer and moister than when fresh, smelt strongly, and was alkaline.

In the remaining observations no battery was used, but the flesh was enclosed between different metals, which were connected by wires: arranged like this, a single electromotor was formed by each piece, the results being the same as though a weak current had been transmitted from an external source.

Exp. C.—Flesh enclosed between silver and lead. The appearance was much the same as with zinc and silver, and only marked in a less degree; beneath the silver the surface was alkaline; and beneath the lead, it was hard and white, but not adherent, and acid.

Exp. D.—Flesh between platinum foil and zinc. The platinum surface was not perceptibly changed, the zinc one was pale red in color and very hard, the hardness extended more or less right through.

Exp. E.—Flesh between magnesium and silver. The only change here was on the magnesium surface, the metal was disintegrated, partly converted into a grey-white powder, while the flesh appeared eroded.

Exp. F.—Flesh between tin and platinum. No change on the surface; on cutting it across, the parts between the plates appeared well perserved, while the projecting edges were discolored and decomposing.

The first experiment, A, is, as far as results are concerned, identical with the original one of Dr. Babington's, though differing in detail of performance, and an explanation of it will serve as a key to the rest. Negative and positive electric currents are generated in the silver and zinc battery, the former passing by way of the zinc plate and negative electode—in this case of silver—the latter by way of the silver plate through the positive electrode of zinc to the electrolyte. The fluid to be decomposed, in dealing with animal tissues, may be considered as simply consisting of a solution of chloride of sodium, the acid of which is the negative component and the base the positive. To the negative electrode, therefore, passes the positive or basic component sodium, and hence the alkalinity at the silver plate, while to the positive electrode is attracted the negative chlorine, which uniting with the zinc forms the caustic compound chloride of zinc, which by coagulating the albumen of the tissue forms the hardness described, and causes as well the strong acid reaction.

Exp. D differs from the above rather in degree than in kind, and this, in part, at least may be attributed, I think, to the less degree of affinity, for the positive components of the electrolyte in platinum than in silver. A practical illustration on the living subject of the action of a positive zinc electrode occurred in this Hospital, in the case of a woman suffering from paralysis agitans, on whom the effect of the continuous current to the spine, was being tried. Sponges fastened to strips of zinc foil, formed the electrodes, one of which (the positive) was placed on the nape of the neck, the other lower down, the moistened sponges lying next the skin, the zinc on the outside. A continuous current was to have been passed through these for an hour, but owing to misunderstanding, it was prolonged to twelve, when while no change was visible beneath the negative electrode, the skin beneath the positive one was completely destroyed by the chloride of zinc that had formed.

The remaining experiments speak for themselves, and go to prove that of all the metals tried, silver forms the least irritating electrode as shown by its chemical action, while if escharotic action were wanted a positive electrode of zinc would fulfil the object. The comparative painlessness of the zinc electrode as a caustic was pointed out in the cases previously published, and again is seen in the patient with paralysis agitans, on whom such an action was never suspected until the removal of the sponges.

(*To be Continued.*)

The Proprietors and Staff of the *Lancet* celebrated its fiftieth birthday on Saturday last at the Freemason's Tavern.

PHYSICAL SOCIETY.

The first meeting of this society took place last Saturday evening, Mr. Cock, the Hon. President, in the chair.

After some introductory remarks from the Chairman, Mr. Lubbock read a paper on "Retention of Urine."

Having restricted himself to retention in the male sex, he went systematically through the subject, first dividing the cases into functional and organic; subdividing the functional into—1. Want of power in the muscular coat of the bladder and urethra; 2. Spasm of the urethra; and the organic into—1. Simple organic stricture, namely obstruction of the canal by organic disease and contraction; 2. Traumatic or cicatricial stricture; 3. The blocking up of the tube by stones, or other foreign bodies; 4. An elongated and adherent prepuce in children; 5. The presence of abscesses or tumours pressing on the urethra; 6. The presence of fractured or displaced bones, external to the urethra; 7. Temporary or permanent disease of the prostate gland. Mr. Lubbock then proceeded to go fully into these headings, illustrating them by various cases he had seen in the wards of the Hospital. In the treatment of spasmodic stricture, he recommended the use of Perchloride of Iron in repeated doses to overcome the spasm, and considered the various forms of operation to relieve retention at some length, arriving at these conclusions. Firstly, that in cases of stricture, not known to be impermeable, and where the prostate is not enormously enlarged, or the bladder habitually contracted, the bladder should be punctured by the rectum. Secondly, in cases of stricture ascertained to be impermeable, tapping the urethra at the apex of the prostate is the operation that should be preferred. Thirdly, in cases of enormously enlarged prostate, where the bladder cannot be punctured by the rectum, on that account, perforation of the prostate may be necessary, though very rarely the case, and if severe cystitis exist, and the agony of catheterism is is unendurable, Mr. Bryant suggests making a clear incision into the bladder, as in lithotomy, to allow the urine to flow away.

Mr. Ashby congratulated the society on the thorough and exhaustive essay just read. His experience, however, was against the value of Tinct. Ferri Perchlor. in stricture, and he preferred gumelastic to silver catheters.

Mr. Rigby was deceived by the name of the paper. He had expected to hear the subject treated of from a medical point of view, and not merely as stricture of the urethra; he referred to retention in fevers and in difficult labours.

Mr. A. K. Newman agreed with Mr. Rigby that the subject had been treated of too closely after the book. He thought the matter had been thoroughly exhausted by some able surgeons, and but very little improvement was made now-a-days. He referred to the number of false passages sometimes found at post-mortems, and called attention to hysterical retention of urine. He recited a case of stricture, with retention, treated internally, and followed by sloughing of the scrotum, and numerous urinary fistulæ.

Mr. Pye-Smith thought the necessity of a surgical consideration of stricture was proved by Mr. Newman's case. He stated there was no fear of collapse from the evacuation of the urine in the supra pubic operation, and referred to the possibility of retention of urine after severe operations.

After a few words in explanation from Mr. Newman and Mr. Rigby,

Mr. Chicken rose and defended Mr. Lubbock's choice of a subject, and his consideration of it; with regard to hysterical retention, he thought nearly the same condition arose, when men were unable to pass water in the presence of others.

Mr. Golding Bird recited the case of a child, from whom he attempted to remove with the forceps a stone impacted in the urethra, the urethra was injured, and he was obliged to cut down upon the stone; in another case he would do this at once. He mentioned an explanation he had read of the use of retaining a catheter in a case of enlarged prostate, the enlarged middle lobe was thus pushed aside, and contracted adhesions in its new position, by which it was prevented from returning to obstruct the flow of urine. In puncture per rectum the base of the prostate cannot always be reached, and the surgeon must not be distressed at not finding it. He thought that as drugs, Liq. Potassæ and Hyoscyanus were of use, but would be glad to hear an explanation of the use of Tinct. Ferri Perchloridi.

The Chairman had found no use from Tincture of Iron. He referred to the possibility of injury to the vas deferens in the operation of puncture per rectum, and subsequent atrophy of the testis, and to retention of urine following ligature of piles.

Mr. Green would have liked to have heard more about the operation of passing the catheter, and treatment by the catheter, and referred to cases now in Job ward.

Mr. Lamb referred to the injection of warm oil down the urethra in cases of stricture, and to the occasional presence of Douglas's pouch low down, as a point to be considered in puncture per rectum, and in answer to Mr. Blackmore, explained the process of injection oil.

Mr. Williams would always precede the catheter by warm bath, opium, and leeches.

Mr. Snook pointed to the anatomical structure of the bladder, explaining the retention of urine in paralysis.

Mr. Morris asked for an explanation of the occurrence of retention in a case of cystitis, where the catheter had been frequently used for washing out the bladder.

After a few words in reply from Mr. Lubbock, Mr. Chicken proposed, and Mr. Pye-Smith seconded, a vote of thanks to Mr. Howse, on his retirement from the Secretaryship of the Society. This was carried unanimously; as was also a vote of thanks to Mr. Cock, the Honorary President, proposed by Mr. A. K. Newman, and seconded by Mr. Golding Bird.

The meeting then adjourned.

MEDICAL WARDS.

—o—

CASE OF INTESTINAL OBSTRUCTION—OPERATION—DEATH.

A. T., æt. 56, was admitted into No. 5, Clinical Ward, on September 29, 1873.

Patient, male, gives very good history, both family and personal. Has been a hard-working man; has never been ruptured; has suffered from piles for forty years. Seventeen years ago was ill with obstruction of the bowels, but after five days, by the use of enemas, he was enabled to pass a motion, and completely recovered, his bowels having been regular ever since till Sept. 21, when he ate some tainted meat, which was followed, after some hours, by sudden and severe pain in the abdomen around the umbilicus. Next day he vomited, vomit smelt very offensive. Sept. 23—Injections were used, vomiting continued. Sept. 24—Another injection, nothing came away with it. Sept. 28—Vomiting continued, and nothing passed from the bowels. Sept. 29—He was brought to the Hospital; the abdomen was found to be tense and tympanitic, and some of the distended coils of intestine could be observed through the walls of the abdomen; there was some dulness on percussion in the right iliac region, where the abdomen was especially full and hard; he had not passed a motion, or blood, or mucus, since the 20th; there was severe pain about the umbilicus. Temp. 98·9, pulse 124. Ordered Belladonna and Opium.

Sept. 30.—Stercoraceous vomiting, some pain and difficulty in passing his water, but the quantity is good.

Oct. 2—Another large injection was tried—oil followed by gruel—but only about a pint could be introduced; he was consequently put under chloroform, and kneading the abdomen resorted to; this was thoroughly performed, it being remarked that the patient "could no longer complain that his bowels had not been *moved*."

Oct. 3—Much the same; the fulness in the right iliac region appears to take the form of a coil of small intestine, much distended. Temp. 99·3, pulse 84.

Oct. 4—Was delirious last night, the abdomen is rather less tense than it was, there is still pain about the umbilicus, but it is not very severe. Temp. 98·6, pulse 78.

Oct. 6—Delirious during the night, but does not appear worse this morning; the lump remains, and other coils of small intestine can be traced. Temp. 98, pulse 92. 5 p.m.—an injection of turpentine administered; some motion came away with it.

Oct. 7—More distressed, much stercoraceous vomiting; at 4 p.m. it was decided to operate; an oblique incision was made over the inguinal canal, which was found to be quite normal; therefore the incision was extended, and the abdominal cavity laid open; some coils of distended intestine lay directly beneath the wound, and upon exploring with the finger these coils were found to be constricted by a band, probably due to old peritonitis. This was divided, but, unfortunately, at the point of constriction, the bowel had ulcerated through, and a little fæcal matter escaped; the edges of the perforation were brought together with carbolised gut sutures, and the bowel returned. A Morphia suppository was introduced.

The patient, unfortunately, only survived the operation three hours.

Post-mortem.—The divided ends of the adhesion were found attached to the mesentery, where it unites with the intestine, separated from each other by about 2ft. of intestine, which, having slipped under the band, caused the obstruction, without becoming strangulated; a line of destroyed tissue marked the position of the band across the included mesentery and the seat of perforation in the bowel wall. There was no peritonitis.

The following cases were admitted from Sept. 28 to Oct. 4, 1873.

PETERSHAM.

No new Cases.

PHILIP.

15—General Paralysis

16—Abdominal Tumour

26—Rheumatism—Morbus Cordis

32—Typhoid

48—Chronic Rheumatism

STEPHEN

1—Rheumatism
4—Albuminuria
6—Peritonitis
8—Epilepsy—Gastric Disease
9—Aneurism—Dead
13—Rheumatic Gout
19—Morbus Brightii
25—To and fro Aortic
28—Qnotidian Ague
33—Typhoid
35—Typhus
38—Abdominal Tumour—Cyst
39—Fibroid Phthisis
41—Hæmoptysis
46—Rheumatism (Gout ?)

MARY.

25—Retroverted Uterus—Conical Cervix
26—Malignant Disease of Cervix Uteri
41—Vesico-vaginal Fistula
45—Abortion

ADDISON.

5—Ulcer of Stomach (?)
9—Carcinoma Mammæ—Paraplegia
11—Tertiary Syphilis
14—Erysipelas in Face
19—Aneurism and Dilation
30—Chorea
33—Phthisis
34—Phthisis
37—Phthisis

MIRIAM (Clinical).

21—Acute Rheumatism

JOHN (Clinical).

4—Pyrexia from Constipation
5—Obstruction of Bowels—Operation—Death
6—Morbus Cordis
10—Lardaceous Degeneration of Liver and Spleen—Syphilomata
16—Peritonitis following Fractured Ensiform Cartilage

(We should be saved much trouble if the Clinical Clerks would kindly write up the diagnoses when the Physician goes round.)

SURGICAL WARDS.

—o—

We are indebted to Mr. Lubbock for the report of the following

CASES OF AMPUTATION AFTER INJURY.

W. B., æt. 62, was admitted into No. 7, Lazarus Ward, on October 1, 1873.

Patient, who is a labourer, was, at about 10 a.m. of the above date, driving a cart, when the bridle of his horse came off and it ran away. Whilst standing on the shaft to arrange the bridle he fell, and the wheel passed over the left leg and shoulder; his leg being crushed below the knee he was at once brought to the Hospital in a more or less insensible condition. A compound fracture of the tibia and fibula in the middle third was found to exist, the tibia being exposed for a distance of three or four inches, and the soft parts were much lacerated. There was also a subglenoid dislocation of the left humerus. The leg was immediately amputated at the knee-joint by Mr. Howse. The elastic bandage having been applied, and the india-rubber cord twisted round the lower part of the thigh, a long rectangular flap was cut in front, the patella dissected out, and a posterior flap, also rectangular, but shorter on account of the effused blood. The operation was performed antiseptically; some of the bleeding vessels were twisted, and others tied with carbolised gut ligatures.

Oct. 2—A little discharge or bleeding from the wound. Temp. 100·5, pulse 104.

Oct. 3—Dressed for the first time since the operation; a little air and blood were found to exist, the synovial sac extending upwards under the quadriceps, a vertical incision about ½ in. in length was made in this position. 11 p.m.—Temp. 100·6, pulse 90. Dressed antiseptically, and placed on a short splint.

Oct. 4—Temp. 100·2, pulse. 92.

From Oct. 4th to the present time, the wound has been dressed in the same manner, the temperature has never exceeded 100, the pulse never more rapid than 94 in the minute, and the general condition is good. With respect to the wound ½in. of the anterior flap sloughed away during the day succeeding the operation, but produced scarcely any irritation by so doing. The cartilage of the external condyle of the femur is visible, and will probably be removed by exfoliation.

W. S., æt. 32, was admitted into No. 2, Lazarus Ward, on October 2nd, 1873.

Patient, male, at about 9 p.m. his left arm was crushed by the wheel of a donkey engine in a screw steamer. He was taken to the police station, where his arm was bandaged up by a surgeon, who sent him on to this Hospital, where he arrived at about midnight. It was found that his arm had been completely divided about 2in. above the elbow joint, the lower portion of the arm being brought separately; the soft parts were much lacerated, and much blood was effused. The arm was immediately amputated by Mr. Howse, in the middle third. The india rubber cord having been applied, anterior and posterior flaps were made by transfixion, both deep and superficial sutures were used, and the whole operation performed antiseptically, carbolised gauze, kept in place by bandage and strapping, being susequently applied.

Oct. 3—Wound painful. Midnight—temp. 104, pulse 144.

Oct. 4—Wound dressed antiseptically. 10 p.m.—temp. 101·5, pulse 116. Since then, until the present time, the wound has been dressed as after the operation. The general condition has remained good, the temperature never exceeding 101 and seldom reaching 100. The pulse never more than 100 per minute, owing to the great muscularity of the patient, the swelling that took place after the operation was very considerable, and the deep sutures became consequently too tight, and caused sloughing to take place at the point of pressure; the disturbance, however, caused by the irritation was of but little consequence

The following cases were admitted from Sept. 28 to Oct. 4, 1873.

ACCIDENT.

1—Fractured Skull—Death
1—Fractured Patella
2—Compound Fracture of Tibia and Fibula
4—Concussion of Brain
5—Internal Injuries, between the buffers of an engine
11—Compound Fracture of Tibia and Fibula
23—Compound Fractured Skull, Trephined
25—Compound Fractured Femur

CORNELIUS.

No new Cases.

MARTHA.

1—Carcinoma
4—Bursa on Anterior Surface of Abdomen
5—Tumour in Left Breast
8—Fractured Leg
7½(cot)-Burn
13—Bullet Wounds
20—Severe Contusions
21—Burns
22—Fractured Femur
23—Stricture

LYDIA

4—Disease of Ankle
8—Ulcer at Rectum (probably Syphilitic)
16—Bad Knee
20—Nævus

NAAMAN.

2—Runover
8—Fractured Jaw (Treble)
11—Cleft Palate

LAZARUS.

3—Fracture of Right Fibula
7—Contusion of Right Foot
9—Tumour on left outer wall of Nose
10—Left Arm crushed by Machinery—Amputation
11—Urethral Calculus
13—Diffused Cellulitis of Right Hand
16—Compound Fracture of Left Leg—Dislocation of Left Humerus
22—Small Growth on Great Toe of Left Foot

JOB.

13—Epithelioma of Tongue
14—Fistula in Ano

LUKE.

11—Epithelioma of Tongue

CHARITY.

No new Cases.

DORCAS.

11—Ulcerated Leg
16—Nævus
19—Abscess of Hip

BARNABAS (Ophthalmic.)

8—Congenital Cataract
11—Left-eye Blow—Antechamber full of Blood
12—Injury from Burn
14—Cataract
16—Opacities of Cornea
24—Corneal Opacities

RUTH (Ophthalmic).

32—Cataract
35—Syphilis—Closed Pupil
36—Cataract
39—Cataract both Eyes
41—Glaucoma
43—Cataract, Left
46—Granular Lids—Corneal Sides—Pupil contracted
47—Sloughing Ulcers and Ulcers of Cornea
48—Cataract

OUR NOTE BOOK.

The Spleen never suppurates, except from Pyæmia or Embolism.

Ascites is induced by four forms of Liver Disease—1. Simple Cirrhosis; 2. Thickening of the Capsule; 3. Syphiloma of the Liver; 4. Simple Chronic Atrophy.

On the second or third day of the Fever, the the temperature is a point of distinction between Typhus and Typhoid; in the former it rises as high as 105 dg. F., in the latter to only about 102 dg.

In pleurisy the temperature rarely rises above 103 dg.; so if found higher in a case of Pleurisy, Puenmonia should also be suspected.

Albuminuria is a complication of Erysipelas.

The ill effects of lead are Colic, Paralysis, especially of Extensors of Forearm causing "Dropped Hand," Granular Kidney, and it is connected with Gout.

Lardaceous disease is caused by Syphilis, Phthisis, and Chronic Suppuration, especially connected with bone.

Phthisis and Morbus Cordis seldom go to gether.

Nausea or Vomiting is of the first importance as an initial symptom of Erysipelas in surgical cases; it is most constant.

Eczema and Scabies are often seen together; the Eczema may be the result of the irritation of the Scabies, or of the Sulphur Ointment used to cure it. Storax is preferable to Sulphur in Scabies, both, because it does not set up irritation, and also because the patient does not know what it is given for. In treating Scabies, have one thorough application of the ointment, and then discontinue it to see the effect; or you will not know, whether it is the Scabies or the ointment, which is keeping up the Eruption, should it not disappear.

The male Acarus Scabie is distinguished from the female, by being smaller, by having suckers on the innermost pair of posterior limbs; and by the parts corresponding to the genital organs being distinctly marked.

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Southwark Bridge Road, S.E.
October 9th, 1873.

There are two vacancies for the post of Clinical Assistant at above Hospital; to be held for a period of three Months. Applications and testimonials to be addressed to the "Medical Committee."

Further particulars on enquiry at the Hospital.

(Signed)
J. C. STEELE,
Superintendent.

Physical Society.

The Society will meet next Saturday Evening at 7,30, when Mr. Williams will read a paper on "Hydrophobia."

Fred. Taylor, Hon. Sec.

RECEIVED.—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

EDITORIAL NOTICES.

All communications to be addressed to
The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.
And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about he Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed:

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Session GUY'S HOSPITAL. 1873 and 1874.

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Guy's Hospital Gazette.

VOL. III.—NO. 3. SATURDAY, OCTOBER 18, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

As annalists of the structural alterations rendered necessary by the progressive requirements of the Medical School, we are bound to take special notice of the arrangements which have been carried out during the autumn recess for the better development of the Anatomical Department. We question whether it is to the advantage of any Hospital incorporated as ours is with a Medical School that the locality in which a knowledge of Anatomy is best obtained, should be forbidden territory to the outside public, and be beyond the reach of the sanitary reformer; for, while every conceivable interest from the dwellings of the poor to the palatial mansions of the rich have been fruitful subjects for scientific discussion, no one has ever dreamt of invading the inner recesses where Anatomy is taught, and of penning a treatise on the best method of constructing a Dissecting Room, or of providing measures for the preparation and safe custody of subjects employed for educational purposes. Had an enthusiastic member of the Social Science Congress visited our Dissecting Room last winter, and witnessed the study of Anatomy under difficulties, which oppressed both teacher and taught, he would have been fully justified in bringing the matter under the serious attention of the late conference. We have to congratulate ourselves and our fellow-students, however, that the necessary reform has been effected without the usual pressure from without, and that the reconstruction and improvement of the Dissecting Room and its accessories are as complete as the limited extent of the foundation ground on which they stand would allow.

The main feature of the alterations, and the only one in point of fact which has involved any extension of the territory sacred to the school buildings, consists in the enlargement of the Dissecting and Demonstrating Rooms respectively. This has been done by extending the long axis of the main building to the footpath of the roadway, in front of the Medical Hospital, and by incorporating a considerable portion of the old Demonstrating Room into the area of the new Dissecting Room. Paralled with the Dissecting Room, and occupying part of the new space gained in front by the extension, as well as by utilizing a portion of the old Demonstrating Room, is the new Demonstrating Room or auxiliary Anatomical Theatre, which is intended to accommodate at least a hundred students, and which has evidently been designed to make the most of its capacity. We would advise gentlemen having a tendency to vertigo, or who are scrupulously careful of their powers to eschew, for the present, the upper benches of this room until some means are employed to prevent them doing penance to the law of gravity. The Dissecting Room now completed will be found to have increased accommodation by fully one-third—some say one-half—more, and although it has been robbed of its symmetry to a certain extent by the lateral addition, it has gained in internal effect by the extension to the roadway, and by the increased light obtained, partly by the lengthening of the lantern roof, but mainly by the fine window of enamelled glass which graces its eastern aspect. Among other alterations to the rooms we are glad to see a better provision made in the means of warming. Our old friend the clumsy-looking stove, which was supposed to disperse its heat to the uttermost corners, but which in reality was limited to its immediate vicinity, has been superseded, and a series of steam pipes, covered with an elegant open grating, has been carried round the basement of the walls by which, it is hoped, a sufficient amount of warm air will be introduced to render the rooms comfortable in the coldest weather. The site of the former stove has been covered, on a level with the floor, by an open grating for the purpose, it is surmised, of drawing off a portion of the foul

air from the room by the extractive force communicated to the tall chimney at the back of the premises by the fire at its base. Whether this minor arrangement will be successful or not it is premature to state, but there can be no doubt of a sufficiency of ventilation being obtained by the lantern roof and especially by the east-end widow, which has been furnished with moveable sashes. Passing the entrance to the Dissecting Room, and on the left side of the passage-way, a spacious and well-lighted apartmeut has been constructed on the ruins of what was formerly the box and refuse rooms. Special provision has been made in this new room for injecting and preparing subjects for dissection, and we can only express a wish that the genius who presides over the department will see fit to follow the course of improvement inaugurated for his benefit. An additional floor entering from an open staircase has been added to the Injecting Room, containing two rooms for the Physiological Laboratory, which has been remodelled to meet the requirements of the lecturer. This is among the greatest improvements in the re-construction, and will no doubt be found of the greatest utility. On the right on entering the main passage the first noticeable alteration is the entrance to the new vault, which has been excavated under the Museum, and to which access is obtained by a somewhat precipitous inclined plane, which it is intended to guard off by a barricade, and by an open grating to admit light and air. The vault itself is 7ft. in height, and about 40ft. long, and in fact occupies the entire space under the Museum. It has been tolerably well lighted by glass doorways and by windows in front on the ground line looking towards ths roadway, and from its large capacity it may be found serviceable for many purposes, although we understand it is intended mainly to be used as a catacomb during the summer months of the year. A little further on to the right, and facing the Injecting Room, are the new Lavatory and Box Rooms. As it was found impracticable to stow away more than a hundred and fifty students' boxes in the Lavatory, where no doubt they would have been most accessible, an upper floor, entering from the stair leading to the Physiological Lavatory, has been added to this portion of the building, where provision has been made for a hundred and sixty additional lockers. These new lockers are intended to be fixtures, and to be numbered consecutively, each student being provided with a key marked with a corresponding number to that marked on the locker. Adjoining the Lavatory and Box Rooms are the rooms intended for the Prosectors and Demonstrators. The Prosectors' Room occupies the site of the old room, but it has been made twice as large, and the means of lighting it have been greatly improved. It is now entered from the open passage at the back, which runs parallel with the new building, the garden side of the passage being shut off by the old wall which formerly did duty as the main support of the old injecting room and lavatory. This wall remains intact, except at that portion facing the Prosectors' Room, where it has been lowered a few feet to supplement the lighting. It is very possible that this latter arrangement may be found objectionable, on account of the room being overlooked from the Hospital airing ground, and having its hidden mysteries exposed to the curious, but with this exceptional detail, which may soon be remedied, we are bound to state our conviction that it would have been difficult to suggest how more could have been made out of the limited space or in the short period of time which has been allowed for the alterations to be carried out.

The Practical Physiology Demonstrations have again commenced, Messrs. Bull and Utting being appointed Assistants.

The Prosectors in Anatomy for the present Session will shortly be appointed.

ORIGINAL COMMUNICATIONS.

—o—

ELECTROLYTIC TREATMENT OF ULCERS.

By C. H. Golding Bird.

(*Continued from Page* 10.)

The following cases are reported from notes taken at the bedside, on each occasion of dressing :—

Case 1.

H. S., æt. 6, was admitted, under Mr. Bryant, in January, 1873, with a burnt arm. On July 3, the surface of the sore on the arm was as follows :—Irregular, with pale large granulations, raised above level of surrounding skin, with pus lying in the interstices between them. Scarcely any attempt at skinning. It occupied the front and outer part of the left arm and forearm, extending for 3in. both above and below the elbow. In this condition the ulcer had been for some weeks closing very slowly indeed, and always presenting the unhealthy flabby surface described ; various dressings had been applied, and the arm was straightened on a splint. The child appeared well in health, and was up and about the ward every day.

July 3—Morning—Blister size of sixpence formed on left shoulder. Evening—One plate of silver foil was placed on the blistered surface, the cuticle being removed ; and another

one over the lower half of the ulcer, and covered with a compress of lint and gutta percha, the whole being firmly strapped down. To each plate was one end of a copper wire soldered, the other end being attached to the zinc and silver plates of the portable battery already described which was moistened with salt and water and enclosed in gutta percha, and fastened to the splint on which the patient's arm was extended. The positive electrode passed to the blistered surface, the negative one to the ulcer. Though but one battery was employed a distinct shock was felt every time that the circuit was completed. The arm, plates, splint and all were enveloped by a bandage in order that the patient might go about as usual, care being taken to protect the wires from injury and to keep them insulated.

July 5—Dressing removed for the first time. The part of the ulcer covered by the negative electrode was level with the surrounding surface; clean, with red, healthy granulations, new skin appearing at the circumference for nearly the depth of $\frac{1}{4}$in. The upper part of the ulcer, where simply wet lint had been applied, presented the same appearance as on the 3rd inst. The blistered surface was rather drier, otherwise it was unaltered. The battery, though in constant use for 48 hours, deflected the galvanometer needle 30°. Water dressing only was used for the next three days.

July 8—The blister having healed, one silver plate (positive) was applied to the ulcer above the bend of the elbow, the other to the part below, care being taken that the two did not come in contact. The mode of application and connection with the battery were as before, except that two cells were now made use of. At first three were put in current, but the shock and muscular spasm, as well as the intolerable burning pain to which they gave rise when the circuit was completed, required one of them to be removed. That part of the ulcer that had already been treated, was still clean and healthy, but the granulations were becoming rather flabby and pale, while the upper part looked as at first.

July 10—Dressing removed. The ulcer presented the same healthy appearance as after the first application, and both parts of it were skinning. There was one point of difference, however, in the fact that the surface beneath the positive electrode was redder, more vascular, and bled more easily when touched than that beneath the negative. Water dressing.

July 12th—Plates re-applied as before. Both parts of the ulcer retained their healthy aspect, but the upper portion now both in vascularity and color was indistinguishable from the lower. On the latter portion two pieces of skin were transplanted and were covered by the negative electrode.

July 14—Dressed again. The ulcer was skinning all round, and its surface still very healthy. Both pieces of skin had taken, and were double their original size. Plates re-applied with this difference, that the positive electrode (under which the greater stimulating action had been observed) was put over the grafts on the lower half of the sore; the negative on the upper half.

July 17—Lower half, the type of a clean, healthy, healing granulating ulcer; both grafts alive and growing, upper half also healing but rather less active in appearance. From this date, the electrolytic treatment was discontinued; and cold water dressing alone used. The ulcer, as was expected, did not after this keep up to that point of healthy action it had attained; but though relapsing somewhat it never again returned to its original indolent condition. The patient left the Hospital in September; one small place remained open on his arm.

In this case a positive cell was used on each occasion of dressing, but the same freshly charged electrode was employed throughout; the negative one having become corroded, was changed more than once. Though both poles of the battery have the same action, the positive one is seen to have more powerful effect; probably the fact that under it free acid is developed, will explain this. Position, either with regard to the other plate, or to the body, seems in no way to influence result, for the more powerful action of the positive over the negative electrode, was the same both when it was placed above and below the elbow. Transplantation had been resorted to, but never a graft had even taken, but so suitable a soil seems not to have been obtained before. This patient, I find on enquiry, left the Hospital in September; his arm had almost healed, one small place alone remaining open.

Case 2.

A. R., æt. 18, admitted into Charity, under Mr. Cooper-Forster, May, 1873.

This girl, the report describes as pale and unhealthy-looking, and as having at the time of her admission, on the outer side of the left leg, 6in. above the ankle, "a sore, with a good deal of discharge; bleeds a good deal, looks very unhealthy and angry, and the surface raw." She also has albuminuria.

July 18—The ulcer was as follows:—Skinning at the edges, the whole surface was flat and even, level with the surrounding skin, red and raw, but not bleeding, rather tender and covered in part with small florid granulations, and marked with ramifying venules.

This case I treated as case 1. applying the negative electrode of silver to the ulcer, and the positive electrode to a blistered surface formed in front of the ankle. Two cells of the battery were strapped to the leg below the knee; the patient

kept her bed, as she had done for months passed. There were no enlarged veins on the leg, nor was there any known cause, other than a constitutional one, for the ulcer. The patient described it as first commencing as a "pimple." It had been variously treated, while tonics had throughout been administered.

From the 18th to 21st of July, the plates were used, but at the end of that time, no change whatever being observed, they were discontinued. Beneath the positive electrode on the foot, a small circumscribed eschar formed, owing to a fragment of zinc having adhered to the silver plate. An ulcer resulted, but it soon healed.

The patient is still (October) in Hospital, and the ulcer is in *statu quo*.

The case is instructive as showing the uselessness of this form of treatment to ulcers that require a sedative application. From the description given of the ulcer, benefit from a stimulating application could be scarcely expected The result obtained was not therefore unlooked for, although the less powerful of the two electrodes was the one applied to the ulcer.

(*To be Continued.*)

CLINICAL LECTURES.

—o—

S. O. HABERSHON, M.D.,

ON A CASE OF INTESTINAL OBSTRUCTION.

[Dr. Habershon commenced his lecture by reading the report of the case which was given in our last number, in which the obstruction arose from the pressure of a band of adhesion across a portion of the small intestine, about an inch and a half above the ileo-cœcal valve.]

The history of the case presents many interesting points, which we will now proceed to consider. It was clearly a case of obstruction, but the question is, what form of obstruction? For, as you know, there are several varieties, and I think it will be our best plan to run over them. They may be placed under four heads:—

1. Purely *Spasmodic* obstruction. This spasmodic contraction of the bowel occurs in both the small and large intestine. Patients sometimes will not permit the bowels to act, as in some cases of painful piles; I have known an instance where the patient died from obstruction, with stercoraceous vomiting, on account of spasmodic contraction from painful piles; but stercoraceous vomiting is rare in spasmodic obstruction; yet I remember a case where the vomit was nearly stercoraceous during the passage of a gall-stone, in which the spasmodic contractions of the duct had become transmitted to the intestine. So *always* bear in mind that obstruction may be purely spasmodic; spasm often accompanies organic stricture of the intestine, but I do not allude to these cases.

2. *Mechanical obstruction.* The cause may here be either external or internal to the bowel. The case I have just read to you was one of mechanical obstruction, in which the cause was external; in hernia the cause is external. Another form is when the bowel is twisted on itself; this may occur in the small, but more frequently in the large intestine, especially at the sigmoid flexure, which sometimes becomes distended, and topples over into the pelvis. One cannot help thinking in such a case that, by inverting the patient and shaking him well, it might sometimes be returned to its proper position. Bear in mind that this is a simple mechanical cause of obstruction, and sometimes a fatal one. More rarely, this same thing happens with the cœcum. Then we have, again, as an external cause, *bands of adhesion*; you cannot tell exactly of what form—it may be a fibrous band, the result of old inflammation, as in this case; it may be the appendix cœci crossing over the end of the small intestine, or a bit of adherent omentum, or a knuckle of intestine may pass through a hole in the omentum, or a diverticulum, formed by the remains of the omphalo-mesenteric duct—may be the cause; moreover, tumours sometimes cause obstruction by pressure: all these are *external* causes. *Internally* we have growths in the wall of the bowel, the most frequent position for this is in the sigmoid flexure, about 13in. from the anus; the growth is generally of a fibroid character, sometimes scirrhus, but you will always find it more fibrous than cellular; it causes so much contraction of the gut, that it has the appearance as though a piece of string had been tied round it. This occurs in adult life, or in advancing years. New growth sometimes attacks the small intestine, the transverse colon, the cœcum, or the rectum, where it often comes within reach of the finger.

Intus-susception is another form of internal obstruction. By this we mean that one portion of bowel has slipped into another—in much the same way as, when taking off a kid glove, the end of the finger gets invaginated into the base of the finger. When once intus-susception has formed, it gets worse by the peristaltic action pushing it further in, and the included portion of intestine swells, and becomes strangulated; but the obstruction is not usually complete, some flatus, or mucus, or blood, from the intense congestion of the bowel, is passed. This obstruction produces severe colic, and the bowels may act; then, after a time, another similar attack, and they act again, and so on, perhaps for months, when the case at last ends fatally. I remember the case of a boy, who always had such an attack as this, and passed a motion after his friends had been to see him. It occurred so frequently that something wrong was suspected, and his excretions were carefully analysed for arsenic, and it was nothing more than that the act of sitting up, and the excitement of seeing his friends, caused the bowel to slip in further, and so brought on the attack. It is not uncommon to find an intus-susception at the post-mortem which has not produced any symptoms; this may occur during the last moments of life, or in the convulsions of some diseases, especially cerebral disease in children. A common position for intus-susception is for the ileum to become invaginated into the cœcum; this sometimes takes place to such an extent that it may be felt in the rectum. I remember in one case the whole of the cœcum, the ascending colon, and some of the ileum sloughed away, and yet the patient recovered. I mention this to show you how cases *may* recover. This same patient lost a great part of his leg from gangrene, and still recovered, showing great tenacity of life. An intus-susception generally gives rise to a tumour sufficient to be recognised by palpation of the abdomen.

Foreign bodies, such as stones, bits of fish-bone, masses of magnesia, &c., are another internal cause. I remember the case of an old lady, whom I thought was suffering from a malignant obstruction; by the vagina a large hard mass

could be felt in the rectum, which seemed like a mass of malignant disease; the sphincter being too irritable to allow of a proper rectal examination, we quieted the spasm by giving opium, and then discovered that the supposed malignant mass was a foreign body—the poor old lady was delivered by the forceps of a lump of hard substance, the remains of innumerable fish-bones, for she had lived for months on fish. Sometimes a large gall-stone is sufficient to cause obstruction—it passes down the duodenum to the jejunum, and lodges there. It very rarely happens that a mass of impacted fæces causes complete obstruction; it may cause vomiting, but fluid fæcal matter will pass.

Such, then, are the forms of mechanical obstruction:—the *external*—hernia, twists, bands, adhesions, and tumours; the *internal*—new growths, intus-susception, foreign bodies swallowed, gall-stones, and impacted masses of fæces.

3. Obstruction the result of *inflammation*, as in peritonitis or enteritis, in which the intestine becomes paralysed by the inflammation. Be on your guard for such cases; much harm has been done by their not being recognised, but badly treated. Remember that the bowels had better not be acted on for a fortnight than that the peritoneum should be irritated. Simple constipation does not kill.

4. *Sympathetic* obstruction occurs with renal, vesical, uterine, or cerebral diseases. In renal disease the bowel passes near the seat of severe and painful disease, it undergoes sympathetic contraction, and constipation is the result.

(*To be Concluded in our next.*)

J. COOPER-FORSTER, F.R.C.S.,

ON A CASE OF TREPHINING FOUR MONTHS AFTER INJURY, WITH SUBSEQUENT ERYSIPELAS AND DEAD BONE.

Gentlemen,—I may tell you in commencement, that I shall always endeavour to give my clinical lectures in the operating theatre, since I think we ought if possible, to have the cases before us, which form the subject of the lecture. The case I am about to bring before you to-day is a rare one, one that you will not often see, and one of great interest, not on account of its rarity, that should lead you generally to take less interest in a case; but because it illustrates one or two general principles. All that the man is coming into the theatre to-day for, is to have a piece of dead bone removed from his skull, but the case has a very long history, and this dead bone is only an accident in it; it is from the history we shall learn the most.

He was admitted into the Hospital last April. By the report, we find that he gave a good history, both family and personal; he had had gonorrhœa with orchitis in youth, but it was not followed by sore throat, or rash; he denied syphilis. Nine years ago he received a blow on his spine, from which he lost the use of his right leg for six weeks, sensation remaining perfect. Four months ago—from last April—he received a blow on the head, which stunned him, he has felt queer in his head since, and had a lump in the position of the blow. Since the last fortnight he has had severe pain in the head, and yesterday—before admission—had a fit, after being five minutes insensible, he regained consciousness; but went off into another fit, in which he was brought to the Hospital.

On admission.—Boatman, æt. 39, strong, tall man; lies on his back; great pain in his head, with a general spasm of his muscles. Bear in mind that this spasm of the muscles means irritation of the surface of the brain, in this case meningitis. There is some numbness of the left leg and forearm, but no loss of sensation, indicating that the deeper parts of the brain are not involved. Pupils normal. I may say that I am not disposed to put much faith in the condition of the pupils in these cases. There is some nausea, furred tongue, &c.

On 26th April, the day after admission, he lost the power of his left leg and arm, and could not see as well with his left eye as with his right. This condition indicates increased pressure, but we also find entered by Dr. Taylor, that the twitchings of abdominal and thigh muscles appears to be due to irritation. On raising the left arm, over which he has no power, it is spasmodically held for a second, then drops a distance, is again fixed, and finally falls to the bed, so that, while I grant you we have here evidence of pressure on the deeper parts of the brain, yet, we have more indication of irritation of the surface.

He was now seen by Mr. Howse, who did as any other surgeon would have done in such a case, as I should have done myself, disbelieved his statement of never having had syphilis, and gave him iodide of potassium, supposing his trouble to be a node in the skull, pressing on the surface of the brain; but we found in this case, that his denial of syphilis was perfectly true; the fits became more and more frequent.

Now, gentlemen, picture to yourselves this case,—a man, such as I have described, with constantly recurring epileptiform convulsions, and spasmodic contraction of his muscles, and who had had a blow on the head four months previously, since which he had always felt queer. There can be no further doubt about it, this must be the result of some ostitis, originating in that blow; having then a knowledge of the cause, and of the position of such a cause, the treatment was clearly to remove it; so on May 1st, I trephined the skull, and here is the piece of bone I removed. I will hand it round, and you should look at it well, for it is a typical specimen; you see on the outside it is about as rough as it can well be, and the inner surface is far, very far, from being as smooth as you know the inner surface of the skull to be normally, and here is another great point, its thickness; have you ever seen a skull this thickness? Well, perhaps you may have, but it must have been a rare specimen; I am sure you will all grant that this is much thicker than a normal skull should be, evidently this is the result of ostitis from the blow; it has set up inflammation in the dura mater, and so caused the convulsions. Had we left this man alone, nature would have endeavoured to cure him, but the process would have been so slow, that he would probably have sunk under it; I think we may fairly say, that this man's life has been saved by trephining, for, upon looking at the report again, we find that two days after the operation, he can raise his left arm, and move his left leg; he has no more fits, but only a little occasional twitching of his muscles. Then he gets an attack of erysipelas, the origin of the dead bone, for which he is coming into the theatre to-day; it led to an abscess at the back of his head, which was opened towards the end of May. After this the report progresses very smoothly with some occasional diarrhœa, &c., but at the commencement of the vacation it comes to an abrupt stop, and it is only from the man himself, that I have discovered that he has had once, something like a fit, since that time.

It becomes a question, when to remove this dead bone? We may not be able to get it away yet. The reassonthat I am about to try in less time than is ordinarily allowed for dead bone to separate, is this: you have heard that wounds about

the face and scalp heal very rapidly, and that this is on account of the good blood supply; now the same cause which tends to make wounds heal rapidly, leads dead bone to separate rapidly; if it were in the leg, I should leave it two or three times as long. We will have him in now, and make an attempt; it is quite possible we may fail. You see he walks very fairly indeed. Here is the place where I trephined him, you know that, in your books, it is recommended not to trephine near the median line, for fear of injuring the superior longitudinal sinus; in this case I went as near as it was possible to go, and it only needed care; it would have been no use to have trephined anywhere else.

We are putting the patient under the influence of methyline, when he is insensible, we shall continue with ether, since I considered it the best anæsthetic.

[Mr. Cooper Forster then cut down upon the dead bone, but finding that it had not become detached yet, he at once desisted in his attempt to remove it at present; he discovered that it was the inner table which had not given way yet, therefore there was no object in cutting away the dead part. He remarked, that we had no means of telling whether the bone had completely separated, and that he should not renew his attempt for two or three months; he had learnt, however, something that he did not know before, namely, the size of the piece of bone; it was as big round as half-a-crown, and thick. If, even, it had been six or seven months since the original operation, it would have been a short time, for such a large piece of bone to have become completely detached.]

MEDICAL WARDS.

—o—

The following cases were admitted from Oct. 5 to Oct. 11, 1373.

PETERSHAM.

28—Hydrocephalus (?)
5—Gastralgia
17—Aphonia
8—Right Hemiplegia—Facial Paralysis

PHILIP.

3—Purulent Pleuritic Effusion in Chest (left)
5—Chorea
9—Acute Rheumatism
23—Emphysema—Capillary Bronchitis—Enlarged Liver
25—Partial Paraplegia
27—Neuralgia
28—Acute Rheumatism
30—Ascites—Œdema
31—Diffused Psoriasis—Emphysema—Bronchitis
36—Partial Hemiplegia (Right)
41—Morbus Cordis—Dyspepsia—Anasarca

STEPHEN

16—Tonsilitis
21—Right Partial Hemiplegia
24—Delirium Tremens
26—Albuminuria
31—Mitral Regurgitant
32—Right Hemiplegia
42—Typhoid Fever
45—Icterus (Syphilitic ?)

MARY.

2—Aphasia—Right Hemiplegia
10—Subacute Rheumatism—Systolic Apex Bruit
15—Typhoid Fever
16—Rheumatic Fever
18—Incipient Phthisis
21—Rheumatic Fever
25—Retroverted Uterus
31—Pregnancy, Hypertrophied and Enlarged Cervix
34—Albuminuria
41—Sharp Retroflexion of Uterus—Fundus Level with Os

ADDISON.

No new Cases.

JOHN (Clinical).

1—Aneurism—Ascending Aorta
3—Diabetes and Albuminuria
7—Acute Rheumatism
11—Typhoid
12—Indian Fever—Hepatic Abscess

MIRIAM (Clinical).

17—Muco-enteritis. &c.
19—Epileptiform Fit
27—Acute Rheumatism
28—Pleuro-pneumonia

SURGICAL WARDS.

—o—

The following cases were admitted from Oct. 5. to Oct. 11, 1873.

ACCIDENT.

9—Fractured Tibia and Fibula
12—Fractured Patella
15—Fractured Femur and Cut Head
17—Fractured Tibia and Fibula
24—Fractured Tibia and Fibula

LUKE.

2—Ostitis of Humerus
4—Ostitis of Femur
11—Stricture of Urethra
12—Fistula in Ano
14—Ostitis of Femur—Distension of Joint
19—Necrosed Bone after Trephining

DORCAS.

3—Exostosis of great Toe
15—Malignant disease of Jaw
21—Dislocation of Hip

JOB.

15—Chronic Synovitis
4—Hernia
3—Necrosis
16—Ecthyma
21—Cut Knee
23—Ulcer in Popliteal Space

MARTHA.

1—Ulcered Leg
2—Bad Arm
3—Cut Head
21—Stone

LAZARUS.

4—Crushed Fingers

NAAMAN.

28—Tumour in Hand

CHARITY.

4—Dislocation of Hip, (Left) Reduced
11—Ulcered Right Leg
12—Ulcered Nose
19—Necrosis of Os Calcis

LYDIA

4—Disease of Ankle Joint

CORNELIUS.

14—Fractured Ilium, Right
19—Fractured Spine (?)

BARNABAS (Ophthalmic.)

13—Cataract
15—Cataract

RUTH (Ophthalmic).

43—Iritis
44—Closed Pupil
45—Cataract

There will be a vacancy for Assistant House-Physician, on account of the resignation of Mr. Golding Bird, on the 1st of November.

Candidates for the same are requested to send their applications to the Treasurer on or before Tuesday, the 21st,

FOOTBALL CLUB.

—o—

On Wednesday, October 8th, a general meeting of the Guy's Football Club was held in the Anatomical Theatre, Mr. G. Power in the chair. The object of the meeting was to elect officers, and make general arrangements for the ensuing session. Owing to the absence of Mr. Elliot, the secretary for last year, there was some delay in commencing the meeting, but it was eventually resolved to proceed without him.

It was then proposed and seconded, that Mr. W. W. Pinching who has been Captain of the Club for the last three years, should be re-elected. This was carried unanimously, amid general cheering.

It was then proposed and seconded, that Mr. D. Gilbert should be Secretary. This was also carried unanimously.

The Captain then stated, that a new ground had been secured at Blackheath, adjoining that used by the Blackheath Club, and he hoped that this would meet with more approval than the old ground at Nunhead. He further stated that a challenge had been received from the Bartholomew's Football Club, for a match to be played this season, and put it to the meeting whether it should be accepted or not. Some of the old members having represented that the last match played against Bartholomew's, three years ago, was attended with much unpleasantness—ending, in fact, in a free fight—it was decided by a large majority that the challenge should be declined. The chairman strongly urged upon all first year's men to join the Club, and play in the opening game on Saturday, stating that there were several vacancies both in the First and Second Fifteens.

A resolution was then passed that all players should be required to wear the Guy's colors, and after a vote of thanks to the chairman, the meeting separated.

[The above was accidentally omitted from our last.]

The opening match of the season was played on our new ground at Blackheath last Saturday, and was very evenly contested, neither side obtaining anything beyond one or two touchdowns. Wells and Gilbert picked up for sides. We were glad to see a good many new men playing, and some of them certainly looked promising for our teams this year. Next Saturday the First Fifteen plays, St. George's Hospital, at Blackheath; and the Second Fifteen, Wimbledon School, at Wimbledon.

It is by mistake that Mr. T. Cooke's Classes have been advertised of late as being held in the Borough Road, and his Tablets on *Physiology* as being the only ones published. For correct information see advertisement on this page.

Received.—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

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Guy's Hospital, S.E.
And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about he Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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VOL. III.—NO. 4. SATURDAY, OCTOBER 25, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

—o—

ELECTROLYTIC TREATMENT OF ULCERS.

By C. H. Golding Bird.

(*Continued from Page* 20.)

Case 3.

For some notes of this case, as well as for assistance in dressing and watching it, I am indebted to Mr. Paley, the dresser to the case.

A. K., æt. 17, was admitted into Charity, under Mr. Cooper-Forster, May, 1873, for ulcers on both arms, the result of a burn seven months before.

Up to August, when I first saw her, the patient had kept her bed, and had had various applications to the ulcers, which had also been transplanted from time to time; they had also been dressed antiseptically by Mr. Paley. Though not absolutely unhealthy, they were yet healing but slowly at the time I took them in hand; and the plates were applied in order to give the patient a chance of a more rapid recovery.

The plan adopted differed from that in Cases 1 and 2. The state of this patient compelling her to remain absolutely at rest in bed, I made use of a battery fixed to the head of the bed, as described in my first paper. Three gutta percha cells were fastened together, and kept charged with dilute acid, so that each, or every other day, the plates could be lifted from one to the other, and fresh acid obtained thus, without disconnecting the wires. The electrodes of insulated copper wire passed from the battery to the patient, lying on or beneath the pillow according to circumstances, while they were sufficiently long to allow of any chance movement without a strain being put upon them. The pieces of silver foil attached to them, were fastened upon the ulcers as in Case 1, by means of strapping and a compress of lint. To avoid repetition it may be here stated that while as a rule only one pair of plates was employed, yet at times a second was put into circuit, the object always being to have such a current passing as should give a very decided shock on making contact, but without leaving a permanently sore sensation when the circuit was completed. Anything beyond this was not only painful to bear, and therefore unnecessary, but very speedily destroyed the negative silver electrode.

Aug. 14—The ulcers were situated on both surfaces of the left arm. The two principal on the upper surface were selected, viz., one the size of half-a-crown, on the front of the arm just below the shoulder; the other near the elbow and measuring $2\frac{3}{4}$in. by $2\frac{1}{4}$. They were granulating uniformly rather raised above the level of the skin, were skinning very slightly at the border, and discharged profusely.

12 noon—Positive electrode applied to larger sore, the negative to the smaller one near the shoulder. Sharp shock felt on making contact.

4 p.m.—No shock felt by patient on breaking and making contact, though the current was felt to be passing freely, by the tongue.

10 p.m.—Same observation made with same result; when another battery was introduced into the circuit, a shock was felt.

Aug. 15—11 a.m.—Dressings removed, ulcer under positive electrode had a distinct blue line of about $\frac{1}{8}$in. in depth all round of new skin; granulations flatter, discharge much diminished. The negative plate was reduced to an impalpable black powder all over the surface of the smaller ulcer; before, however, removing this plate, the positive one

was cleaned from the mucoid discharge, that adhered to it and was again replaced; one battery now gave a shock as on first application. The silver plates were renewed and replaced.

9 p.m.—No shock felt on breaking circuit.

Aug 16.—11 a.m.—On removal, the negative plate was again found destroyed, presenting the black and white colors observed in one of the experiments already reported. The lower ulcer looked very healthy; about ½in. of new blue skin at circumference; granulations even and level. Upper sore smaller, the pulverized plate concealed most of its surface, there was no evidence of new skin at its border, but a circular scab had formed; it appeared to be drying up. Re-dressed, only one electrode used.

Aug. 17—1 p.m.—Negative electrode covered beneath with white paint-like patches, but not disintegrated. Surface of the sore *alkaline* in reaction. Beneath the positive electrode the new skin had increased in depth, while the discharge on the sore was markedly *acid*.

This mode of treatment was carried on until the 27th, on which day the smaller sore, which had scabbed at the circumference thoughout, rather than skinned, had all but closed, indeed was rather too small to use for the passage of the current. The lower ulcer was much less than at first, although the rapid rate of skinning, first mentioned had not latterly been kept up. As it seemed that the ulcer no longer needed a stimulating application, the plates were discontinued and zinc ointment dressing employed. No further diminution in size had been noticed for two or three days.

Aug. 19—Mr. Paley transplanted seven pieces of skin beneath the positive electrode, every graft took and lived, though some eventually disappeared when the purulent discharge increased in quantity, under ordinary dressing. The loss of all electric shock on the 15th, after the plates had been applied a few hours, seemed to be owing to the greater resistance offered to the current by the insulating discharge from the wound that adhered to the positive electrode; a slight addition to the intensity of the electric current overcame this.

This patient is still in Hospital, and I learn from Mr. Paley, who carefully watched her during last month (Sept.), that the ulcer treated has had throughout a healthier aspect, and has, in his opinion, been healing at a quicker rate than its neighbours on the same arm.

(*To be Concluded in our next.*)

PHYSICAL SOCIETY.

The second meeting of this session was held last Saturday October 18th, 1873, Mr. H. Ashby in the chair.

After Dr. Taylor had read the minutes of the preceeding meeting of the society, the Chairman called upon Mr. Williams to read his paper on "Hydrophobia," of which the following is a short abstract:—

The author first gave his reasons for choosing Hydrophobia, as the subject of his paper, his great reason being the fact that he had seen three cases of the disease at the Nottingham Hospital, and he thought the notes of these cases, with a few remarks on the disease in general, would prove acceptable to the majority of his audience. He also wished, if possible, to rob Hydrophobia of some of the sensational character which had been given to it by the profession and the public. After giving reasons for objecting to the name Hydrophobia, Mr. Williams went on to speak of the way in which man is infected by the poison of the mad dogs, and of the varying period of incubation of the disease. He concluded by criticising the treatment adopted in the cases mentioned, and by suggesting what might be done if any one of his hearers should be called upon at any time to treat a case of Hydrophobia.

Mr. Lubbock, after thanking Mr. Williams for the interesting and practical paper he had just read, expressed his opinion that the disease should be considered medical rather than surgical. He did not agree with the author, that solids were eqnally difficult with liquids of degentition in Hydrophobia, and he was disposed to think that in dogs the disease was not endemic, but probably always carried by inoculation. He remarked that the poison might as probably be secreted by the fauces or lungs, as by the salivary glands. He mentioned hydrocyanic acid as a useful drug, and ice to relax the spasm of the pharynx.

Mr. Giblin considered this disease a most unfortunate one for everyone,—both patients and doctors,—except Mr. Williams. He described a method of treatment pursued by a Moscow peasant, which resulted in recovery. It consisted in the internal use of a decoction of *Planta Genista*; but chiefly in opening and cauterising the pustules, which formed under the tongue.

Mr. Jalland described a case which he had seen at the Nottingham Hospital; he called attention to the pain which often occurs in the cicatrix of the bite, and reminded Mr. Williams, that a case had occurred at Guy's, either at end of the year 1865, or at the beginning of 1866.

Mr. Paul mentioned some arguments advanced by Dr. Burder, of Bristol, suggesting the possibility of Hydrophobia being an idiopathic disease, and not necessarily caused by the bite of a mad dog. He did not agree with Mr. Williams, that the poison directly entered the blood vessels; but thought it more probable, that it underwent a double zymosis, like the poison of syphilis, and therefore recommended the excision of the cicatrix at any period of the disease, on the same principle that Dr. Wilks recommended the excision of the chancre in syphilis; to prevent further infection of the system, by a continued local fermentative process. He thought the fact of full-bodied healthy people being most affected, only a natural resemblance to the action of better known zymotic poisons, and, bearing in mind the good results of venesection followed by transfusion of blood, recorded in some cases of zymotic diseases, recommended the practice in Hydrophobia.

Mr. Fry agreed with Mr. Lubbock, in considering Hydrophobia a medical, rather than a surgical disease; it resembled epilepsy, in both cases distinct aura were often felt. He thought the poison, whatever it might be, remained at the bitten spot till the period of recrudenscence when it was conveyed into the system through the lymph and blood-vessels. Mr. Williams had mentioned cases

bitten three years ago, which he did not consider out of danger yet. Mr. Fry was of opinion that the disease always showed itself in ten weeks.

Mr. R. J. Pye-Smith thought the society ought to be congratulated on the excellent practical paper Mr. Williams had given them, especially for the detailed account of his cases. Mr. Williams had quarrelled with the term Hydrophobia; but, apparently, because he did not recognise the cases, which ordinarily went by that name, and had restricted it to such extreme cases as he had just narated, which might be a different disease from that more frequently met with. He thought the treatment of the vesicles by cauterisation a point worthy of attention. It seemed to him that Mr. Williams had excluded the possibility of a rat bite causing Hydrophobia, purely on theoretical and insufficient grounds, and, upon contrasting the symptoms of rabies in the dog with Hydrophobia in the man, he could not agree with him, that there was sufficient similarity, to make it desirable to change the latter term to rabies. He mentioned, that the Hon. Grantham Barclay had divided dog-madness into two distinct forms, rabies and Hydrophobia, of which only the latter communicated the disease to man, and quoted experiments to show that want of water was not a cause of rabies in dogs; he also alluded to a case, supposed to be Tetanus and Hydrophobia together.

Mr. Rees had read an old book where cases were related, in which, after the most severe dysphagia for days, they were able to eat and drink just before death. He alluded to a case which occurred in Charing-cross Hopital, in which he thought the sympathetic to be most affected, and recommended hydrocyanic acid for its action on the sympathetic system.

Mr. Shadwell remarked that in India, where they did not know Greek, and therefore could not be mislead by a Greek term, the natives were in the habit of testing a dog for Hydrophobia, when he showed any signs of madness, by placing before him a dish of water; if he lapped it, he was not supposed to have this dangerous form of madness Mr. Shadwell thought this native observation to be in favour of two forms of dog-madness, as mentioned by Mr. Pye-Smith. He recommended hydrocyanic acid in the treatment.

Mr. Harsant, after congratulating Mr. Williams, begged to suggest that the downcast and morose condition, which he had attributed to the primary action of the poison of Hydrophobia, might be quite sufficiently accounted for by the fact of having been bitten by a mad dog, and he (Mr. Harsant) was of opinion, that the poison, during this incubatory stage, was restricted to the cicatrix, of which he recommended the excision, at any time up to the development of Hydrophobia.

The Chairman then called upon Mr. Williams to answer the discussion on his paper, after which Mr. Pye-Smith proposed, and Mr. Hetley seconded, a vote of thanks to Mr. Williams. It was carried unanimously.

We are again compelled to leave over "Our Note Book."

Voluntary Entrance Examination.—T. C. Uhthoff. 1st prize; F. H. Berry, 2nd. prize; J. H. Poland, 3rd. prize; J. Poland and C. St. John Wright, Hon. Certificates.

Guy's Glee Club.—A general meeting of the members of this society was held in the House-Physician's Room on Wednesday last, Mr. Ticehurst in the chair. Mr. Nash was elected the conductor for the present session, while Messrs. Rudd and Sangster were appointed secretary and treasurer respectively, the other two members of the committee being Messrs. Bell and Wilding. The committee is glad to state that the society is in a flourishing condition, and that there is every prospect of a concert being given shortly before Christmas.

CLINICAL LECTURES.

—o—

S. O. HABERSHON, M.D.,

ON A CASE OF INTESTINAL OBSTRUCTION.

(*Concluded from page* 21.)

These, then, being the *causes* of obstruction, let us see which is indicated by the report of our case. In the first place it is not at all like spasmodic obstruction, the history was against it. Then there is hernia, never forget that; I remember a case that was supposed to be asiatic cholera, but was found to be one of hernia; we could find no evidence of hernia here, though there was a little suspicious fulness in the inguinal canal. There was no history of malignant disease, or foreign body, or impacted fæces; and there was nothing to indicate sympathetic stricture of the intestine, no albumen in the urine, no bladder disease, &c. It could not be inflammatory, because there was not sufficient pain, and no fever, the temperature not rising above 99·3; so we were reduced to some external cause, and here the history helped us a good deal; it told us, that seventeen years ago he had suffered from obstruction of the bowels, which might—and as we have since discovered did—give rise to some inflammatory adhesion, the origin of his trouble.

When we decided that the obstruction was probably owing to some old band of adhesion, we talked the case over with Mr. Howse. He preferred colotomy, from the large percentage of obstructions occurring in the large intestine; but I thought that, in this case, it was in the small intestine, for reasons that you will see, as we consider the value of the symptoms in obstruction. *Rapidity*—When obstruction occurs low down in the large intestine, the symptoms are slow, and vomiting does occur for some time; be sure, if vomiting occurs rapidly, the obstruction is in the small intestine. Our patient was taken ill on the 21st September, in twenty-four hours he vomited matter, looking and swelling like fæces. *Vomiting*—Vomited matters from the small intestine may be fæcal; it is said such is not the case, but I have seen it, even when the obstruction was high up. *Pain.*—this symptom cannot be relied on to point out the position of the mischief, in our patient the pain was persistent about the umbilicus; so very persistent in this position, that we were almost led to doubt, whether the tumour, which we felt in the right iliac fossa, could be the seat of obstruction. *Distention* often helps in the diagnosis; if the obstruction be at the sigmoid flexure, the cœcum will be enormously distended, out of proportion to the other parts, the transverse and descending colon will also be distended. In this case, in the earliest stages, there was no evidence of distention of the cœcum or colon, while we could see and feel distended coils of small intestine all over the abdomen. *Peristaltic movements*—These are of great importance, so always look carefully for them with a good light; have the abdomen thoroughly exposed, and look at it diagonally, and you will find in mechanical obstruction, especially at sigmoid flexure, voilent peristaltic efforts to overcome it, most marked in the transverse colon. In this case we saw voilent spasmodic action of the small intestine. This occurs in mechanical obstruction, not in inflammatory, because in the latter the intestines are paralysed; nor is it marked in sympathetic obstruction. *Flatus*—The passage of flatus is always a good sign, and it led me to hope favorably, when it occurred in this case; in some instances flatus is the cause of the

obstruction; I remember a case, in which a band, as broad as one's hand, passing over some coils of intestine, was rendered sufficiently tight by the collection of flatus, to cause complete obstruction which resulted in death. The passage of *flatus* is always a good sign. *Passage of blood or mucus*—this occurs very frequently in intus-susception, but it also happens with epithelioma, or ulceration of the rectum. *Hiccough*—is of bad omen in intestinal obstruction, it generally indicates the beginning of the end; it often occurs when sloughing commences. *The Quantity of Urine*—Our patient passed about a pint of urine, which indicated, by its small quantity, that the obstruction was high up in the intestine; when the vomiting is long deferred, and the obstruction is in the large intestine, the amount of urine is proportionately increased. Dr. Barlow explained this symptom by the lesser absorbing surface of the intestines and the consequent diminished secretion from the kidney in iliac destruction, but if vomiting be early and severe the urine is always scanty in amount. It is a good sign when there is not much pain, when the pulse is good, and the patient is cheerful; this was the case with our patient, and it led us to hope for him; but on the morning of the 7th he was evidently worse, his pulse was only 92, but the quantity of stercoraceous vomiting, and his general condition pronounced him worse; and I was not surprised to find that sloughing had commenced.

Treatment.—In reviewing the treatment of this case, I think we pursued the best course that we could under the circumstances. We made full use of injections to try and distend the colon, so as to take off the pressure on the band, but though we tried to introduce large injections of gruel, not very much could be retained. We tried various forms of injection, one of which was oil, this is very useful to loosen and bring away impacted masses of fæces.

In intus-susception some recommend the intestines to be distended with air, I like water best; but some cases in which the intestines have been blown up with a pair of bellows, have done very well. Peristaltic action should be quieted, as it makes matters worse. Opium and belladonna are the best drugs; we used them in this case till they produced delirium, when we were forced to stop them, but they quieted the vomiting, and then we continued the opium in his injections.

Then comes the question of early operation. Well, it has been done, and very few recover. You know that surgeon, are unwilling to open the sac of strangulated hernias so you will easily understand that they do not like to open the abdominal cavity, except as a last resource, and such you see was Mr. Howse's opinion. Looking at this case now, I regret that he was not operated on forty-eight hours earlier; I think the poor fellow would have had a better chance. But there is another reason why we defer the operation: I have seen many cases where there was early stercoraceous vomiting, with rapid pulse, where I have thought there was no hope, where I have summoned the friends to the bed-side, and told them that I feared the only chance lay in an operation; I have known such cases recover, I am afraid to say how many. So one prefers to quiet the peristalsis, and see what may be done by means of injections. If, however, you have evidence of the transverse colon being distended, then you may open the descending colon, for colotomy is a far different operation from gastrotomy, and if you compare the statistics of obstruction left alone with obstruction operated upon by opening the abdominal cavity, I am afraid you will find that those not operated on appear to have the best chance of recovery.

THE VASCULAR CHANGES IN BRIGHT'S DISEASE.*

To Dr. Galabin's fellow-students, who have been witnesses of his first acquiring, and then using his now enviable, skill with the sphygmograph, it will be no surprise that his work on the vascular system in Bright's disease should already have taken a leading place amongst the best contributions to Pathological knowledge. We ourselves have gazed on his wonderful tracings with a curiosity very respectful and a good deal mystified, and now we are happy to avail ourselves of the lucid sketch in which he brings his difficult subject of study somewhat within ordinary compass. If we shall venture to comment on his views it is not so much as critics, rather it is with the object of making it appear how our unlearned notions respond to his teaching. In this spirit we will proceed to offer a few remarks on our author's theories, with regard to the significance of the sphygmographic trace. And first in reference to the signs in it of rigidity or of high tension of the artery.

Dr. Galabin says the sphygmograph lever is tossed by the beat of the pulse, so as to rise above the artery that tosses it; the toss will, we suppose, be effective in proportion as the impulse is quick and free. Now, rigidity of the artery will check the toss, and so lower the first "percussion" wave, so that there would always be a small percussion wave in a *rigid* artery unless the heart were hypertrophied. But a strong heart would force up the lever and give a good wave in spite of considerable rigidity of the vessel, so that when the heart is hypertrophied there may be high percussion wave in spite of arterial rigidity. But, again, if the artery be over *distended* then an ordinary action of the heart will not bring out an ample movement of the artery, unless the vessel be compressed at the spot with a greater weight than would be lifted by the pulse in a healthy artery; in other words, if the tension within overstretches the artery, you need to press harder on it with the sphygmograph to indent it and so to obtain a widening movement at the beat of the pulse. Thus the weight required to bring out the greatest amplitude of the percussion wave comes indeed to be a measure of the arterial tension, while the amplitude of the percussion itself is a measure of the power of the heart over the rigidity of the arterial wall.

As to amplitude of the percussion wave, then, it appears that, assuming the heart to be uniform in its action, the amplitude is inversely as the arterial rigidity; while, as to the tension within the artery, this is directly as the weight required to call out the largest amplitude.

Next we will consider the duration and character of the arterial collapse. In a healthy system, a good deal of the blood will have passed on at the systole of the heart before the aortic valves close, and thus the tension in the vessels will fall before their closure, but upon its occurrence the tension rises again by a reflected wave from them. This reflected wave the sphygmograph shows by a distinct elevation called the "dicrotic wave," but between the dicrotic wave and the percussion wave the instrument shows an intermediate wave which is called the "tidal wave," and is commonly referred to the advent of the gush of blood; while the percussion wave itself is attributed to the sudden vascular tension induced by the heart's contraction.

Dr. Galabin here advances a very ingenious theory, which if it prove to be correct, will most desirably simplify the

* ON THE CONNECTION OF BRIGHT'S DISEASE WITH CHANGES IN THE VASCULAR SYSTEM. London: Smith, Elder & Co.

reading of the sphygmographic trace. Dr. Galabin, in short, believes the tidal wave to be caused by a second bounce of the lever, which after its toss comes down again upon the tide now *falling* and rebounds a second time, producing the "tidal wave" by the rebound. This wave is thus altogether fictitious, and has no representative in the course of things in the artery, however useful it may be to observe its character.

This theory its author does not give us the proofs of in the Thesis before us. But it is so probable, and we have such confidence in his judgment, that we will accept it, especially as no one has ever given any satisfactory explanation of the "tidal wave," or of the slight fourth wave after the "dicrotic wave," to which Dr. Galabin's theory of course equally applies, showing that it is a rebound after the toss of the reflected dicrotic impulse.

There are some points, however, upon which we would wish that in his second edition he would be a little more explicit, or indeed in these columns an explanation would be gladly welcomed. Thus, referring to Dr. Galabin's Plate I., we see that the highest point of the *actual tide* in the whole discursion is shown in a dotted line below the *percussion* wave, but in Fig. 6 the percussion wave is distinctly lower than the tidal wave. Now, regarding the percussion wave as a toss, from which the tidal wave was a rebound, we do not clearly see how the rebound comes to be so much higher than the toss. We would ask whether it would be consistent with the author's view to consider that in No. 6 there is a very slight toss indeed forming the low percussion wave, so that the lever falls on the *still rising* wave instead of coming down upon the *falling* wave, as in a healthy pulse, Plate I. ? If so, then, the second or tidal wave is in No. 6, not a mere rebound, but represents the acme of the actual tide of blood in the vessel now truly recorded by the instrument, while in Plate I. the acme is represented as occuring during the toss and as being unrecorded by the instrument. If this be admitted as to No. 6, it may be a question how often the second or tidal wave does really represent the actual height of the tide in the vessel, does it so in No. 4 and No. 7, or No. 9 ? Is it a frequent thing for the tidal wave to show the real height of the tide in the vessel ?

Another point we should like to see made clearer, is in reference to the first notch—that between the percussion and the tidal waves. In Dr. Galabin's diagrammatic figure, Plate I., wherein he gives the four waves caused in the instrument, and puts a dotted line to represent the two waves of the real pulse, we observe that in the notch between the percussion and tidal waves the line of the sphygmographic trace is made to dip much under the dotted line of the real pulse. Dr. Galabin views this dip in the sphygmographic trace as a fall of the lever from the toss which threw it above the height of the wave. But why should this fall carry it down under the proper wave ? It can only do so by actually pressing down the surface of the vessel. But can the very trifling momentum of the lever depress the blood wave so as to give such an indentation as this ? It appears to us that the lever would fall on to the wave but not depress it. Indeed, Dr. Galabin, at page 16, says, "Owing to the inertia of the long lever it is carried up a little too high, and, when in falling, it meets the true arterial wave it is again tossed up and so forms the tidal wave." He then describes the falling lever as *meeting* with the true arterial wave, not depressing it. Further, the author describes the percussion and tidal waves as caused by one wave without choosing which of the two most commonly or more nearly represents the true wave. But it appears to us, from a study of his tracings by the light of his theory that we may conclude that while the percussion wave is always false when there is any trace of tidal wave, the tidal wave perhaps commonly indicates the actual rise in the blood tide. So that it is doubtful, whether the tidal wave is not after all generally at least due to the raising of the artery by the gush of blood, according to the common view. Dr. Galabin's discovery, then, applies chiefly to the percussion wave in ordinary cases, he proving that the percussion wave is a product of the instrument caused by the toss of the lever through the abruptness of the first impetus on it. While the tidal wave indicates the height to which the real current reaches after the lever has fallen upon and partakes the actual movement of the vessel.

But we find in what professes to be a review of Dr. Galabin's work, we have gone off altogether into a digression upon a point which, although of great interest, forms but a small detail in the amount of valuable evidence and reasoning which he has crowded into his little book. We recommend all our subscribers to read it carefully, and we are sure they all will find real pleasure as they profit by the clearness of the author's statement of views, which are often uttered by others very confusedly. His readers will not fail to recognise the careful and modest estimation of the really valuable new facts he brings to bear on the questions he discusses so ably, while his temperate and courteous treatment of those whose views he is obliged to criticise will prove quite refreshing to any, who remember the mutual wrath and bitterness which has of late rendered the literature of renal disease so undesirably acrimonious; and will raise the hope that, through his good example, the irritation of Bright's disease may be once more confined to the kidneys.

MEDICAL WARDS.

—o—

The following cases were admitted from Oct. 12 to Oct. 23, 1873.

PETERSHAM.

3—Epilepsy ?
12—Infantile Paraplegia
19—Ulcerated Throat

STEPHEN.

7—Hæmaturia
10—Erysipelas
12—Sciatica
18—Albuminuria
20—Bronchitis
22—Heart Disease
30—Hæmaturia
40—Abscess of Brain
46—Rheumatism

PHILIP.

1—Enteritis—Gastric Ulcer ?
16—Aortic Regurgitation—Cephalalgia
35—Phthisis—Dead
35—Bronchitis—Emphysema

MARY.

12—Chronic Rheumatism
13—Erysipelas, Facial
22—Phthisis
27—Conical Cervix Uteri—Dysmennorhœa
45—Dysmennorhœa—Sinace Cervix Uteri

ADDISON.

6—Phthisis
14—Erysipelas
16—Typhoid
29—Sore Throat
33—Tonsilitis

JOHN (Clinical).

4—Paraplegia

MIRIAM (Clinical).

20—Left Pleuritic Effusion
22—Dropsy, following Scarlatina
25—Phantom Tumor
29—Sequela of Enterica—Bronchitis

SURGICAL WARDS.

—o—

The following cases were admitted from Oct. 12. to Oct. 23, 1873.

ACCIDENT.

21—Compound Fractured Knee-joint and Femur, R.—Compound Fractured Tibia and Fibula, L.—Wound in Arm—Wound on Head
23—Concussion—Death
26—Compound Fracture Right Leg—Amputation—Death
26—Wound opening into Knee-joint
31—Injury to Toes

CORNELIUS.

4—Fractured Jaw
8—Scalp Wound
14—Injury to Hand
11—Fractured Spine—Death
18—Dislocated Shoulder—Fractured Scapula, Clavicle, and Thigh

LYDIA

1—Lipoma
3—Fractured Tibia and Fibula
4—Severe Burn
9—Tumour in Left Mammary Region
9—Contusion of Leg, (Blood Tumour)
13—Strumous Ulcer of Leg
17—Cleft Palate
18—Fractured Neck of Femur
19—Stricture of Rectum
20—Contused Thigh
21—Stone
24—Bite by Dog
Erysipelas of Left Hand and Forearm—Private Room

MARTHA.

3—Bad Legs
4—Hip Disease
19—Abscess in Face

NAAMAN.

15—Fistula
16—Fistula

JOB.

4—Aneurism
6—Fracture of Right Patella

LUKE.

17—Scrotal Hernia

DORCAS.

6—Injury to Knee
9—Fracture of Femur
15—Disease of Knee Joint
16—Nævus
24—Obstruction in Throat (Tracheotomy)

BARNABAS (Ophthalmic.)

1—Cataract
6—Congenital Cataract
8—Dislocation af Crystalline Lens
11—Iritis—Removal of Right Eye
12—Iritis after Injury
13—Congenital Cataract
15—Cataract
19—Cataract

RUTH (Ophthalmic.)

29—Glaucoma
32—Closed Pupil
36—Cataract
40—Cataract
43—Iritis
44—Closed Pupil
45—Cataract

OPERATING THEATRE.

—o—

REMOVAL OF A NÆVUS.

By Mr. Bryant.

This was a case, said Mr. Bryant, of some interest, on account of the position of the disease, which he was about to remove. It was a nævus occupying the very centre of the upper lip, involving both sides exactly alike. It had travelled upwards, and affected just the tip of the nose, and downwards to the mucous membrane of the mouth. It was of congenital origin, and he had watched it for several months. He proposed, when he first saw it, to leave it alone, in the hope that it would disappear; but in that he had been disappointed, as the growth had steadily increased. He therefore, now, felt bound to do something for its removal. The question therefore arose as to what that something should be. As it involved the whole tissue of the lip, an external application—such as they might employ in the case of a simple cutaneous nævus—was altogether out of the question. If it had been of the subcutaneous form, the ligature would probably have been best. In the present case, however, neither of these plans would be effectual. It would be wisest, therefore, he thought to remove it altogether, more especially as it was situated in a part where disfigurement was of great importance. He shonld be unable to remove more than nine-tenths of the growth, but as the vessels supplying it would be cut off from the remainder the other tenth would probably wither and disappear. If not it would have to be dealt with afterwards in detail. Another mode of treatmennt, of which they had heard a good deal lately, was that of injection, but he must caution them to be careful in thus treating nævi about the face, as sudden death had been known to occur from clotting in the veins, and subsequent embolism. Such a result was very sad when operating for a disease which did not in itself affect life. The child having been placed under chloroform, Mr. Bryant then removed the growth by a V-shaped incision. The vessels were twisted, and the edges of the wound brought together with interrupted sutures.

EPITHELIOMA OF THE LIP.

By Mr. Bryant.

This was a case of epithelial cancer of the lower lip. It was first noticed about a year ago, and had been steadily increasing since. As it didnot involve any great depth of tissue—not more than about a quarter of an inch—Mr. Bryant said he did not propose to take it out by a V-shaped incision, as in the previous case, because the base of the triangle would be very broad, obliging him to sacrifiee a considerable amount of healthy tissue, which he was the rather anxious to economise in case of a second operation being needed from the not improbable return of the growth.

AMPUTATION THROUGH THE LEG.

By Mr. Durham.

Patient was a girl of 22 years of age. Her right leg had always been weak, and for many years past she had suffered with disease of the bones of that leg. About seven years ago she was admitted under Mr. Poland, and some pieces of bone were removed from the right tibia; since then she has been in again twice, dead bone having been removed on each occasion. During the whole of this time the wounds made have never completely healed up, and the limb has become weaker, and thus ceased to grow in the same proportion as the opposite limb. The soft parts have also suffered, so that at the present time Mr. Durham remarked there was evidence of impairment of nutrition of the limb, as shown by the apparent stagnation of blood in it, the feeling of coldness, the healing process not having gone on satisfactorily, the degeneration of the muscles into a sort of fibrous structure, and

by the whole limb not having grown like its fellow. Owing to this impaired nutrition the foot had not only ceased to grow but had degenerated, and now presented the appearance of talipes equino-varus. A foot of this description was useless to walk upon ; as a matter of fact she had not stood upon it for seven years. Apart from this she was an intelligent and well enough grown girl, and the question arose what was the best thing to be done. The orthopædic treatment might be adopted to some extent, but it was a question whether it would put the foot in anything like position, and even if it did that leg would still remain much shorter and weaker than the other. They must regard the limb, then, as being not only useless but worse than useless, as it was a considerable drag upon the girl's powers. He proposed, therefore, to remove the limb, and have it replaced by an artificial one, so that very soon, if the case went on as well as they hoped, the patient would be able to get about once again. Mr. Durham then removed the leg at the junction of the upper with the lower third, making a long anterior flap. Esmarch's plan of arresting hæmorrhage was employed and the operation was perfectly bloodless ; vessels were ligatured. On removing the elastic band there was some hæmorrhage ; this was immediately controlled by pressure on the femoral, and Mr. Durham tied the bleeding vessels.

Operation for Cleft Palat.

D. H., æt. 16, was admitted into Naaman Ward, on Oct. 7th, being the subject of cleft palate. The fissure extended through both soft and hard palate ; the harelip which had accompanied it was operated on during infancy. The hard palate appeared to extend less far back than is usual. On the 10th Mr. Durham operated on the patient in the theatre. Having first pared the edges of the fissure in the soft palate, he separated the mucous membrane from the hard palate on both sides, and then pared the edges of the fissure in that situation. By means of wire and silk sutures the parts were then brought together, there being apparently no undue tension on the flaps. The major portion of the operation was performed without chloroform. The interest of this operation lies in the age of the patient and its result more than in its performance. Our readers shall hear its progress.

FOOTBALL CLUB.

I. GUY'S v. ST. GEORGE'S.

Sir,—This match was played on Saturday, October 18th, on our ground, Blackheath. It resulted in a victory for Guy's, one goal, four tries, and six touch downs in goal to nothing. St. George's won the toss and chose the south goal, consequently they had to play slightly up-hill. The ball was kicked off by Robson at 3·20, our opponents never once got the ball half way, and when half-time was called, we had scored one goal, two tries, and four touch downs in goal. Changing goals did not make the slightest difference to our team, the St. George's men were hemmed in as before and when no side was called we had obtained two more tries, and two more touch downs in goal. Lyne Cant, Turner and White played well for St. George's. It would be absurd to name any man in particular on our side, as all played so exceedingly well, in fact I think Guy's men may congratulate themselves on having a team this year, that bids fair to distinguish itself as it did in the days of Davis-Colly and Fred. Taylor. I have heard it rumoured that the Football Club does not want subscriptions, as they do not pay any ground rent this year. I hope no Guy's man will labour under that delusion any longer, as the expenses incurred are much heavier than was anticipated, and as there are between twenty and thirty matches to be played on our ground, how can the Club possibly keep out of debt if men do not come forward with their usual subscriptions ? The following played on Saturday :—Captain—Robson ; backs—Breach and Pearson ; half-backs—Maclean and Finch ; Gibb, Hetley, Collins, Rendall, Elliot, Wells, Gilbert, Wallis, Boughton and Grey.

Your's, &c.,

Lusor.

Matches This Day,

First Fifteen v. St. Thomas's, Clapham Common; Second Fifteen v. Gravesend F.C., Blackheath.

Received.—La Independencia Medica.—A New and Easy Method for the Subcutaneous Application of Morphia, by John M. Crombie M.A., M.D.—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

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BIRTH.

Sutton.—October 22, at the Norwich Borough Asylum, the wife of Fredk. Sutton, Resident Medical Superintendent, of a son,

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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER, at 104, Borough High-street, Southwark, Surrey.—Saturday Oct 25, 1873

Guy's Hospital Gazette.

VOL. III.—NO. 5. SATURDAY, NOVEMBER 1, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

—o—

ELECTROLYTIC TREATMENT OF ULCERS.

By C. H. Golding Bird.

(*Concluded from Page* 26.)

I have frequently been asked the question, "What is the action of the plates?" To every one who has persued the cases the answer must be obvious—the action is stimulant. More facts than one point to this;—the changes observed upon the surface of the ulcer, and the rapid formation of new skin; the acid developed under the positive electrode (which acts to some extent as a dilute acid—and therefore stimulating—lotion); the passage of an electric current; and the negative results in the second case, where the ulcer was of a character, as the description shows, requiring treatment the very reverse of stimulating, namely, a sedative one. The action being determined it is not difficult to define the class of cases for which this mode of treatment is useful: indolent and sluggish sores; especially to those where a mild and continuously stimulating action is beneficial, as in those abruptly-ending profusely-granulating—but not skinning, and copiously discharging—ulcers, the result of burns. As rival to the more powerful applications, as strong carbolic or nitric acid lotions, for foul-smelling sores, or as one to the weaker stimulating applications, where both are acting beneficially, this process does not offer itself; but where these have ceased to act to any purpose, it claims a fair and unprejudiced trial. One drawback it undoubtedly possesses, and that is the time that it takes; but the operator must balance the expected benefit against the time occupied in each particular case; and this is reduced to a minimum if a few batteries and electrodes are always kept ready at hand. The other objection, the formation of an eschar, and so a second wound, no longer exists, for not only now *can* no sore be produced by the silver electrodes—if clean—but even a blistered surface for one plate is unnecessary if the ulcer treated be of sufficient extent to hold both; while if this be not possible, and blistering has to be resorted to, the only reasonable objection that can be offered is one for the operator and not for the patient to make—*i.e.*, that it heals too fast!

The mode of dressing has been sufficiently indicated in the reports of the cases, while the times during which the same dressing will act is about twenty-four hours. There is but one thing as far as I have been able to discover that limits the time (the gradual destruction of the negative electrode excepted), and that is the layer of purulent discharge that underlies the plates. To currents of low tension it seems to act like a layer of mucus as a more or less complete insulator; for, on wiping the metal, the current passes as freely as ever (Case 3). This property of mucus I first learnt from our observant Electrician, Mr. Sandy (to whom I am indebted for much mechanical aid), who noticed that the sponge probe used to the pharynx in galvanisation about the throat ceased to conduct the current as soon as it was coated with a uniform layer of mucus: after being washed it acted again properly. I have since then observed the same fact.

In common with other stimulating dressings, the electrolytic process acts up to a certain point and no further, and when once skinning has been set going healthily, and the surface of the sore is looking well, the plates may be removed in the full anticipation that the sore will not again relapse into the same degree of indolence, but continue to close, while if necessary they can at any future time be reapplied.

There is but one other fact to refer to. The beneficial effect of this process, it has been said, may be fully accounted for by the simple pressure of the metal on the ulcer apart from any other action.

This statement, containing as it does, an acknowledgment of the benefit accruing from the treatment, refers it to what is most evident at a passing glance without taking into consideration the other and more important phenomena. For, though pressure may mechanically reduce a thick and callous edge and even level protruding granulations, it can scarcely be made to account for hypercœmic redness, a healthy surface, and a skinning border; and while adding that I have tried the experiment of pressure only, and found it inadequate to produce the results described, it scarcely seems philosophical not to say logical, to prefer the one inferior mechanica reason alone, to the higher, more powerful, and all but vital forces of chemical action and electricity combined.

A HINT.

I have been lately reading in the current medical literature, lectures, essays and discoveries by men, already eminent, and by others who, if not eminent now, are running a great risk of becoming so by their careful thoughts and researches. Many of these lectures, although spoken to or written for the benefit of the medical profession exclusively, find their way into the hands of lay readers and thus, indirectly, prevent being done the good which they are intended to do. This I think could easily be prevented were it not for our disposition to run to extremes.

A long time ago it was the custom of some shallow-brained practitioners to hide a little knowledge under a great deal of technical verbosity. Hence, among a later generation of well educated and scientific professors, it is the custom to discard technicalities as being the mark of a quack. We have rushed to an extreme. As well might we give up arsenic because many are poisoned by it, or electricity because fools say it is life. There is no science more rich in technicalities than medicine, and none needs them more.

It is useless to blind our eyes to the fact that there is scarcely an adult afflicted with a malady but who has tried, in well-advertised and popular works, to find out the nature of his disease and the appropriate treatment of it. Many go further than this and regularly subscribe to medical journals or buy those numbers, at the railway or other book stalls, which they see by the table of contents, contains matter relevant to their disorder. Thus, writing an essay on a popular medical subject and publishing it in a well-known periodical,—say in the *Lancet*,—becomes almost equivalent to inserting it in the daily press—an acknowledged and serious mistake.

As medical instruction is now conveyed in simple and colloquial English, it becomes almost as easy for a lecture by Professor Neurosis to be understood by Mrs. Ennui, as by Dr. Puzzled, her medical attendant. Fresh symptoms crop up in her case which closely simulate some new disorder, and he is not surprised to find out, after a little time, that a new line of treatment, prescribed by himself and adopted from Professor Neurosis' practice, has effected in her case a speedy cure. For, if she be mimicing an organic disease, she there sees what symptoms are false and what are real; she sees the very instructions themselves of the medical man, so that she is able, by a little study, to become perfect in her deceit. This sort of work suits a hysterical or hypochondriacal patient down to the ground.

These are not theories. I have seen clerks and men of business reading the *Lancet* with the gravity and absorbed interest of a professional man. It may be said "It is to their detriment, let it be so," or "If they will be such fools, they must suffer the consequences of their folly, &c. &c.;" but this is neither to our credit nor their benefit. It is our fault and we ought, and it is our duty, to dissect the matter, and carefully find out how far the pernicious influence extends, so that measures may be taken to remedy it. Take for instance the article in the *Lancet* of October 11, headed "Infanticide," inserted undoubtedly with humane motives. Is it not calculated to do much harm? All this I say is the fault of our running to an extreme, of our discarding technicalities and forbidden their use. In short slang we object to "shop." This is very well in a mixed company, but in professional conversation and serious teaching, where we cannot prevent the curious public eaves-dropping our writings, the rule ought to be reversed. For, to a properly educated medical man, a technical term is as easily understood as a popular one, but to the public it is as Greek.

I think that if, in medical books honestly published for the benefit of the profession, a technical term were used whenever admissible, both patients and doctors would feel the benefit of it. Indeed, if a lecture, on a well-known and common disease, be published in a current medical journal in popular language, the motives of the writer ought to be called in question, almost as seriously, as though he had inserted it for the benefit of the public in an organ of the laity.

"Z."

Mr. Charles J. Davey, of Guy's Hospital, has passed his First M.B. Examination at the University of Edinburgh.

OUR NOTE BOOK.

A mixture containing about 15m. of Tincture of Belladonna, and 2om. of Liquor Potassæ, is an excellent remedy to allay the spasm in stricture.

IN passing a catheter, handle the instrument lightly, *feeling* your way along the passage, and never blindly pressing against a resistance, unless the catheter is held; it is also a frequent error with beginners to raise the instrument from the patient's body before they have introduced it sufficiently far.

THE chief causes of coagulation of blood in the body are—1. Increase of Fibrin (Hyperinosis). 2. Passage over roughened surfaces. 3. Stagnation of bood.

FIVE dangers of early Phthisis are—1. Hæmorrhage. 2. Pneumothorax. 3. Miliary Tubercle. 4. Acute Pneumonia. 5. Acute Pleurisy.

BRIGHT'S disease is a very common cause of fatal Pleurisy.

IF, on removing a kidney, the pyramids of Ferrein show plainly, it is not a very bad kidney.

WHEN there is tubercle anywhere in the body after the age of 16 years, it is sure to be in the lungs also.

NINETY-NINE out of a hundred cases of Hæmatemisis are due to either cirrhosis of the liver or gastric ulcer.

TYPHOID may be accompanied by constipation, lasting from ten days to a fortnight. It is a healthy stool that is so rare in Typhoid.

A CONNECTION has been urged between Albuminuria and Syphilis; but it is probable, that the only association is, that Albuminuria is more liable to occur with a cachetic state of the system.

AT post-mortem the testicle is very frequently found to be affected with tubercle in Phthisis, but this slow deposit gives rise to no symptoms during life.

SYPHILITIC Gummata do not form as such; they are the remains of some more acute process. The question is, what is this acute process? We see something of it when a man comes to us with an enormous liver, and a history of syphilis, and the liver regains its normal size under Iodide of Potassium. We must admit that the liver becomes acutely affected as a whole in syphilis; then why, when we get a case of simple jaundice with syphilis, may we not ascribe the jaundice to an acute syphilitic affection of the liver? Cases of jaundice are now and then seen in the syphilitic ward. A physician of Aix-la-Chapelle remarked to one of London, "You English physicians send your patients to drink our waters for their livers, and we cure them with Iodide of Potassium, which you could do as well at home, for their livers only suffer from the effects of syphilis." Not more than twenty years ago, syphilis was treated in some parts of Germany by starvation, with mercurial inunction, no change of bed or body linen being allowed, nor was the window ever permitted to be open. At one time syphilis was treated by cutting out the chancres, but without benefit; for, as Ricord says, the earliest evidence of syphilis is the first secondary, or constitutional sympton, the hardened base of the sore. It is, nevertheless, a question, whether some process of multiplication or intensification of the poison does not go on in the sore, and if so, whether the early removal of the sore might not prevent the system from becoming so severely affected?

PHTHISIS.

Phthisis, the dread disease, that slays,
With its slow, sure, heartless hand,
The sweetest buds that blossom here,
In England's homes, our fatherland;

Favoured by the fairest women,
That, through the countries of the earth,
Have ever lived to stir our hearts,
And give to love's strong passions birth.

But infested by this dread pest,
That fastens on the tender girl;
For its cowardly grasp is shaken off
By the strength of the uncouth churl.

The girl clothed in the softest skin,
White and pure as the falling snow;
While on her lovely dimpled cheeks,
Two of the freshest roses grow.

Her form is beautiful and slim,
Her hair like silk surpassing fine,
And, beneath the longest lashes,
Eyes of the brightest lustre shine.

Such fall victims on every side,
Each year in our prosperous land,
Yet our Science cannot tell us,
How we may stay its ruthless hand.

Such was the case of one I knew.
She is dead: and sorely do I grieve,
When I compare its giant strength,
With our weak efforts to relieve.

X.

STATISTICAL REPORT OF GUY'S HOSPITAL SURGERY.

SEPTEMBER, 1873.

MALE SURGERY.
Cases treated 410.

Diarrhœa	69
Scalp Wounds	36
Paraphymosis	2
Burns and Scalds	14
Crushed Fingers	23
Amputation of Fingers	1
Teeth Extracted	142
Dislocations—	
Shoulder (a) Subcoracoid	9
(b) Subclavicular	1
Thumb—Metacarpo-phalangeal	1
Ulna and Radius (outwards)	1
Fractures—	
Clavicle	5
Internal Condyle of Humerus	1
Phalanges of Hand	2
Ribs	4
Radius	8
Ulna	3
Olecranon	4
Carpal Bones (Cuneiform?)	1
Metacarpal	5
Nasal Bones	2
Ulna and Radius	2
Inferior Maxilla	4
Humerus	3

FEMALE SURGERY.
Cases treated, 369

Diarrhœa	25
Teeth Extracted	118
Burns nnd Scalds	8
Crushed Fingers	2
Amputation of Fingers	1
Scalp Wounds	5
Dislocations—	
Sternal end of Clavicle	1
Shoulder	1
Fractures—	
Femur	1
Tibia	1
Clavicle	11
Humerus	3
Olecranon	1
Ulna	2
Radius	7
Ribs	4
Phalanx of Thumb	1

J. LACY MORLEY,
Junior House Surgeon.

MEDICAL WARDS.

—o—

We have to thank Mr. Nunez for the following continuation (from page 12, Vol. II.) of the report of the

CASE OF SCHLEROSIS.

June 13—Menstruation recommenced and ceased after some hours.

July 9—Menstruated again.

July 11—The continuous current has been applied three times a week since January 13th with much benefit. No power of walking.

Sept. 15—The shaking has increased lately, and her speech is now evidently affected. Has not been galvanised regularly lately.

Sept. 30—A week ago she noticed an occasional spasmodic movement of the legs which gradually got more obvious. It is worst at night. Her head shakes a good deal when unsupported, and the other movements previously noticed are more marked.

Oct. 2—Ordered, Pot. Bromide gr. xx., Suc. Conii m. x., Syrup. Limon. ½oz. ex aqua, t. d. s.

Oct. 5—Feels better, and walked a short distance, which she has not done for three weeks.

Oct. 16—Last night was very sleepy, and had much shivering for two or three hours. Says she had had wheezing during the day. After three hours she became hot and had a severe pain in her left side and in her forehead, and had great difficulty with her breathing ever since. Has been unable to move her legs since the attack. 1 p.m. —She lies on her back, breathing 28 times in the minute, each inspiration short, forced, and catching. Face congested, livid, and anxious. Skin generally congested. Lips dark, with a tendency to purple. Tongue dark, clear, and moist. Skin feels very hot. Left chest moves better than right. Vesicular breathing absent from whole of right side. Bronchial breathing and bronchophony heard in lower interscapular regions. Pupils contracted. Left face more congested than right. Pulse 150. Mouth drawn to right side on showing teeth. Very drowsy. Loud inspiration on left side. 4.30 p.m.—Temp. 105·4, pulse 172, respiration gasping. Complete unconsciousness. Pupils strongly contracted. Face deeply congested. General mucus râles heard over the chest, and laryngeal râles. Cold sweat in face. 16 oz. of blood taken. Occasional sighs during venesection. Face clearer. Cold sponging over exposed trunk. 5.30 p.m.—Respiration not improved. Temp. 102. About a quarter of an hour later patient died quietly.

Oct. 17—P.M. Muscular rigidity present.

Brain had a shrunken appearance; cut much more toughly than healthy brain; circumscribed patches of grey pellucid matter scattered through the white matter of the cerebrum; large patches in the optic thalami and floor of the fourth ventricle; small patches in centre of cerebellum.

Cord—Patches in medulla oblongata and scattered through the whole cord, but not so circumscribed as in brain.

Heart healthy and contracted; cavities empty.

Lungs—Lower lobe of right lung collapsed and airless; no obstruction in bronchial tubes to explain collapsed lung; no fluid in pleural cavity; pleura normal.

Liver, spleen, and kidneys normal.

The following cases were admitted from Oct. 23 to Oct. 29, 1873.

PETERSHAM.

1—Obstinate Constipation
2—Emphysema
6—Eczema
12—Bronchitis and Emphysema
15—Morbus Cordis (Mitral)

PHILIP.

24—Chronic Phthisis—Cirrhosis—Acute Bronchitis
36—Bronchitis
38—Phthisis, (Left side most)
39—Phthisis

STEPHEN

1—Albuminuria—Morbus Cordis
2—Sciatica and Albuminuria
12—Abscess of Kidney
15—Phthisis, Right
18—Albuminuria—Bronchitis—Emphysema
20—Bronchitis—Systolic Basic Bruit—Œdema
22—Morbus Cordis—Aortic Regurgitant
30—Hæmaturia
31—Albuminuria
40—Disease of Internal Ear—Abscess of Brain (?)
43—Chronic Rheumatic Arthritis
46—Phthisis
50—Phthisis

MARY.

8—Essential Paralysis, Right Leg
9—Rheumatic Fever
17—Phthisis
22—Phthisis
33—Ovarian

ADDISON.

7—Acute Rheumatism
8—Gastric
13—Pleuritic Effusion
26—Rheumatism
28—Paralysis
34—Phthisis

JOHN (Clinical).

7—Pneumo-pleuritis, Left Lung—Acute Bronchitis, Right Lung —Death
8—Acute Bright's Disease
10—Exposure to Cold—Death
14—Paralysis of soft Palate after Diphtheria
15—Epilepsy

MIRIAM) Clinical).

28—Left Hemiplegia, Mitral Disease
30—Spinal Symptoms—Functional (?)
31—Left Pleuritic Effusion

SURGICAL WARDS.

—o—

J. H., about 25, was admitted into Accident Ward on October 29, 1873.

Patient was riding on the engine of a train, when a col-

lision occurred, and he was thrown out, falling upon his head. He was brought into the Hospital in a cart, but was able to walk into the ward with assistance. Soon after he was in bed he had "a fit," and became unconscious. There was considerable hæmorrhage from both ears; stertorous breathing; dilatation of right pupil, and contraction of left. Pulse 123, resp. 36.

Report from Dresser—Seen in the Surgery, at 5 a.m. He complained of pain in the head at the seat of a scalp wound, but shortly after pain extended all over head. Pulse and respiration were then normal. Pupils normal. Patient was pallid, but seemed to be suffering only from faintness. On examining the wound, there was no observable sign of fracture. Wound closed by sutures. Patient then lay on couch for ten minutes, after which his pulse was small and feeble, and he seemed rather drowsy. He then complained of much pain in the head, and was taken into the ward. At 7 a.m., the limbs were rigid and convulsed; lower extremities cold and clammy, right pupil widely dilated, left minutely contracted; left slightly sensible to light, the right not at all. Breathing quick and stertorous. Pulse 136, full and compressible. 4 p.m.—Face suddenly became livid, respiration ceased, though the heart continued to beat some minutes longer; the tongue was drawn forward, but no further internal respiratiou occurred.

P.M.—A long fracture was discovered on the right side of the skull, running across the track of the middle meningeal artery, and an immense clot about 4in. by 3in. by 1in. occupied the position between the dura mater and the bone on the right side, and completely flattened the right hemisphere of the cerebrum on the whole of that side. The artery was carefully examined for a rent, but none was found.

The following cases were admitted from Oct. 24, to Oct. 30, 1873.

ACCIDENT.

3—Pott's Fracture
14—Compound Fracture of Arm
22—Fractured Tibia and Fibula, Delirium Tremens
22—Crushed Toes
23—Fractured Base—Death

CORNELIUS.

2—Fractured Thigh
3—Fractured Ribs
4—Fractured Jaw
5—Cut Throat—Death
8—Crushed Foot
12—Fractured Tibia and Fibula
19—Fractured Tibia and Fibula
20—Injury from fall of Bales of Jute

MARTHA.

7½-Talipes Equino-varus
8—Hæmorrhoids
14—Fistula in Ano

LYDIA

4—Fractured Jaw
11—Bad Foot
19—Ovarian Tumour
21—Injury to Leg

LAZARUS.

No new Cases.

NAAMAN.

2—Hare Lip
5—Stricture of Throat
6—Hernia
10—Hernia
11—Contraction of Knees
19—Stricture
19½-Injury from Van to Chest and Side

JOB.

14—Injury to Knee
16—Retro-vesical Fistula

LUKE.

No new Cases.

CHARITY.

4—Disease of Left Knee-joint

DORCAS.

2—Ulcerated Foot
7—Disease of Throat
9—Scalp Wound and Contusions
10—Ulcered Leg
13—Fracture of Leg
21—Fracture of Leg

BARNABAS (Ophthalmic.)

1—Glaucoma
5—Severe Iritis
4—Accident from Glass
11—Opaque Capsule
12—Injury, Right
16—Closed Pupils
17—Closed Pupil, Cataract
19—Cataract

RUTH (Ophthalmic.)

37—Cataract, Right
38—Cataract, Right
32—Closed Pupils

STUDENTS' BIBLE CLASS.

For more than twenty-five years a number of Guy's Students have met together for the study of God's Word. The meetings are now being held each alternate Tuesday, at 6.30 p.m. (closing at 8 p.m.), at Hibernia Chambers, London Bridge, in the Board Room of the Shipwrecked Mariner's Society, (first floor). They are held amongst the Students alone, and are open to all who acknowledge the Divine authority of Scripture. During the winter Session the subject will be the Discourses of Christ in the Gospel of John; in the Summer, Wisdom, as set forth in the Book of Proverbs.

The next Meeting will be held on Tuesday next, the 4th November, when the portion of Scripture considered will be John 3. xi—xxi.

Application for Cards of Subjects, or any further information may be made to Mr. Arthur H. Jones.

Each Meeting will be announced in the *Gazette* on the previous Saturday.

GENERAL NEWS.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

Examination for the Licence (Second Part or Pass).

October, 1873.

Materia Medica, and Chemistry, in its applications to Pathology, Pharmacy and Toxicology.

1. Whence, and by what processes, are Gallic and Tannic Acids obtained? Describe their chemical properties, and the means of distinguishing them from each other. Mention their preparations, and describe their uses in Medicine.

Mention the Officinal Plants into the composition of which Tannic Acid largely enters.

2. How is Carbonate of Ammonia prepared? Name the preparations of Ammonia, and describe its physiological effects and therapeutical uses.

3. Give in detail the symptoms caused by the administration o poisonous doses of Tartar Emetic, and state by what means this substance can be detected in a liquid containing organic matters. How may the presence of Arsenic be ascertained in an impure sample of Tartar Emetic?

4. How is White Precipitate prepared, and what is its composition? State how you would discriminate between White Precipitate, Calomel, and Corrosive Sublimate.

Questions 1 and 2 to be answered in one set of Books, and 3 and 4 in another and distinct set of Books.

Midwifery and the Diseases of Women.

1. Describe the management of a case of difficult Labour depending on slight contraction of the antero-posterior diameter of the pelvic brim.

2. Describe the causes, differential diagnosis, and the palliative and curative treatment of Prolapsus Uteri.

3. What means would you adopt to prevent the occurrence of post-partem Hæmorrhage in a patient known to have suffered from that accident in previous Labours, and how would you treat it when actually taking place?

4. What are the most common causes of Dysmenorrhea? Describe the principles which would guide you in treatment.

Medical Anatomy and the Principles and Practice of Medicine.

1. Describe the origin, course, and distribution of the Nerves of the Larynx.

2. Mention the chief anatomical causes of Hemiplegia, and the diagnostic signs of each.

3. Mention the chief modes in which Typhoid Fever may be disseminated, and the means of prevention.

4. Give the anatomical characters, and symptoms, and the physical signs, of Acute Pericarditis in its different stages. Mention the chief exciting causes, and describe the treatment.

5. Mention the chief anatomical causes and the symptoms of Obstruction of the Bowels, and describe the treatment.

6. Describe the anatomical characters of Pulmonary Emphysema; its causes and consequences, its symptoms and physical signs.

At the recent Examination at the Royal College of Physicians Messrs. Ransford and Nunez were admitted as Licentiates of the College.

PROSECTORS.

WINTER SESSION, 1873-4.

Ligaments—Messrs. Clowes, Cusack, T. Richards, and Smart.

Muscles—Messrs. Chevers, Maltby, Todd, and Waterhouse.

Arteries—Messrs. Bartlett, Blackmore, H. C. Barton, and A. W. Green.

Nerves—Messrs. Bowen, Bull, Cock, and Snook.

THE NOTICE BOARD.

House Physicians—

Dr. Galabin and Mr. R. J. Pye-Smith.

Junior House Physician—

Mr. T. Eastes (in place of Mr. C. H. Golding Bird, *resigned*).

House Surgeon—

Mr. J. Lacy Morley.

Junior House Surgeon—

Mr. W. H. A. Jacobson.

Resident Obstetric—

Mr. M. Duke.

Junior Resident Obstetric—

Mr. T. D. Ransford.

Physical Society.

Mr. Cock will read a paper on "Congenital Syphilis" this evening, Mr J. P. Beavan in the chair.

FOOTBALL CLUB.

GUY'S v. ST. THOMAS'S.

Sir,—There was no match on Saturday, Oct. 18. A St. Thomas's man came to the Hospital about noon on Friday to say they could not get up a team to play us.

2nd. ELEVEN v. GRAVESEND F.C.

This was played at Blackheath. It was drawn in favour of Gravesend two tries and one touchdown. Mallard (who is a Guy's man) played well for Gravesend. Smart, Much and Johnson played well for Guy's.

Yours, &c.,

LUSOR.

MATCHES THIS DAY.

First Fifteen v. Arab F.C., at Wandsworth Common.

Second Fifteen v. Lewisham F.C., at Lewisham.

ANSWERS TO CORRESPONDENTS.

John Todd—The matter shall receive our early consideration.

E. Hume—Yes. you are quite right; there has been no Index for Vol. II. printed yet, but we hope to have it ready shortly.

ST. THOMAS'S HOSPITAL.—A week or two since we felt bound, for the honour of the Profession we represent, to call the attention of the staff of this hospital to the objectionable practice adopted by one of its members, in offering "twopenny consultations" in a newspaper written ostensibly for mechanics, and edited by the gentleman whose name we then gave. It affords ue, therefore, great pleasure to announce that the gentleman in question has renounced all further connection with that newspaper, thus quickly and frankly atoning for an error of judgment as distasteful to his colleagues as it might have proved serious to his position amongst the members of so honourable a staff.—*Medical Press and Circular.*

THE ROYAL LONDON ORTHOPÆDIC HOSPITAL.—Our readers will remember the not very creditable game which was played at this institution in the early part of last year, and in which, as we stated in our numbers for May 15 and 22, 1872, all parties seemed more or less losers and defeated. We understand that, although it is so long since, it is not to be allowed to die out. An agitation is talked of, and the wire-pullers are already at work with a view to reopen that question, and also to enforce, if possible, Mr. Brodhurst's resignation at St. George's Hospital. Time, the umpire of all men and all things, will doubtless show the solution. —*Medical Press and Circular.*

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

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Guy's Hospital, S.E.
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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

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Guy's Hospital Gazette.

VOL. III.—NO. 6. SATURDAY, NOVEMBER 8, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

We are glad to see the advantages of increased size in our Dissecting Room, so soon tested by a fortunate influx of subjects. Already, we count nearly twenty around the room; and again, around each one we count a goodly number of students busily working away at a clean, fresh dissection. Ah! we sigh, when we think of the subjects in which we sought nerve filaments, at the end of a month of October weather a few years ago; but that is only for recollections of the past, and we are rather led to look forward by these advantages. Forward to the time, when we may all share their fruits, the honour gained to our School by those that enjoy them. We need not say that this fruit is in season during the month of April.

We noticed on the wall some diagrams, very kindly placed there by Mr. Rendle, with which we were particularly pleased; they consists of a diagrammatic representation of all the nerves of the body, from their origin at the plexuses or brain, to their ultimate supply, and also one of the sympathetic system. We would recommend students to copy these into their note books, and learn them up by heart. Whether their examiners would approve of such a mode of learning the distribution of nerves, we cannot say. We know they have a horror of another mode of storing dry detail, the so-called artificial memory, and therefore urge the examinees to be as ready with "Timothy Doth Vex All Very Nervous Pupils," and such like useful "tips," backwards as well as forwards, or they will risk this favourite mode of study becoming too apparent to their examiners, for which sad discovery no one has sympathy up there—save Mr. Stone.

That odd corner, which was thought to spoil the symmetry of the Dissecting Room, has become a most useful part of the room. It will be remembered that, in former years, when the limbs were detached from the trunk for the more ready progress of the anatomical examination, they were located on tressels down the centre of the room, where they were in every-one's way, and where every-one was in their way—a state of things not conducive to harmony among the young anatomists. Such inconveniences are now avoided by making use of this corner, which is already becoming well stocked, for extremities accumulate under the New Act. Excellently well as these subjects are prepared, there never since has been one in the room so well prepared as the first in which the new method was tried. That was nearly three years ago, and we have recently seen a muscle taken from it, through curiosity to see how long it would be preserved; it is now in perfect condition though still moist, and has never even become mouldy, although kept in a damp cupboard only in a pill-box.

While we remind the present students of the advantages, which they receive over those who went before; we would, at the same time, have them remember, that they will have to account strictly for them. That they will not even be allowed to present themselves for examination, until it has been ascertained that they have made good use of these opportunities; for these improvements were not made for their comfort and convenience alone, but that they might assist them to maintain the honour of the School, to which they have the good fortune to belong.

At a Court held Oct. 29, the Lord Bishop of Ripon, Lord Cairns, Lord Lawrence, Mr. Henry Hucks Gibbs, and Mr. Money Wigram were elected Governors of the Hospital, to supply vacancies occasioned by the deaths of the Bishop of Winchester, Sir David Salomons, Mr. Hope Scott, and the late Mr. Money Wigram, and by the resignation of Mr. John Masterman.

PHYSICAL SOCIETY.

The third meeting of the Session took place last Saturday evening, when Mr. Cock read a paper on "Congenital Syphilis." Mr. J. P. Bevan occupied the chair. There were ninty-four members present. Dr. F. Taylor, hon. secretary, having read the minutes of the preceeding meeting, the chairman called upon Mr. Cock to read his paper, of which the following is an abstract:—

Mr. Cock, in introducing his subject, said he thought too many diseases were attributed to Syphilis—either hereditary or acquired—and he wished to prejudice them a little in the opposite direction, so that they might thoroughly investigate the cases. He then went on to say, the ways in which the poison might be communicated to the ovum, and the probability of its being aborted, but if it be born alive the appearance it would present at birth or shortly afterwards. He then mentioned how the evidences of congenital syphilis were obtained, viz., from the child and its parent. He then gave the evidences in the child—1st, in the early stage; and 2nd, in the later stage. Also the evidences derived from the parents, at the same time intimating that merely asking a question and receiving a monosyllabic answer without further investigation was not sufficient to establish a history of syphilis, as these symptoms might be accounted for in other ways, which he named. He then considered some of the symptoms in the child, and thought they were sometimes due to other causes besides syphilis, and which were overlooked from insufficient attention. He then mentioned the possibility of a child acquiring syphilis at an early age, either through the milk of a syphilitic nurse, or from accidental circumstances. He thought that if a child acquired syphilis it would not suffer so severely as if it inherited, as in the latter case every tissue of the body would be built up of poisoned material, whereas in the former, those formed subsequently to the introduction of the poison, would be most likely to suffer. He briefly referred to vaccino-syphilis as one of the ways by which the child acquired syphilis. He then went on to the Morbid Anatomy of those children who were either stillborn, or died shortly after birth, mentioning the organs that suffered usually, and the pathological changes noticed in them, referring to the peculiar conditions in which the lungs are found, and the fibroid changes which took place in the liver; also to the interesting researches made by Dubois respecting the changes in the thymus gland, and Wagner respecting the pathological changes in the bones of children affected with intra-uterine syphilis. He then gave his opinion why those organs should be attacked in preference to others, stating that he thought the organs that were developed earliest and that were most vascular suffered most severely, referring to the lungs, liver, &c. He thought the reason why the bones of the head suffered more severely than the other bones was because they were developed early and received a greater supply of blood during intra-uterine life. He also stated why the bones of the nose were affected oftener than other bones, and in referring to the mucous and cutaneous surfaces, he thought that the carbonic acid passing over them charged with the poison had something to do in producing the cond tions we find. He then went on to look at the disease in a later stage, referring to gummata, nodes, &c., mentioning cases that came under his observation of nodes that were not syphilitic, but were the result of typhoid. In speaking of intestinal corneitis, he thought it was essentially an heredito-syphilitic disease, giving reasons for so thinking. The peculiarly formed and notched teeth were thought to be characteristic of congenital syphilis. He thought ulcers were rarely met with as the result of congenital syphilis, and mentioned a case that was overlooked, and did not get well till treated for syphilis. He mentioned other cases that were said to be syphilitic when there was no history whatever. He then briefly touched upon the question whether a child, the subject of inherited syphilis, could communicate the disease to others by contagion, and whether it could transmit the disease to its offspring, and whether it would be protected from a future attack. He thought there was no doubt about its being capable of communicating the disease, and mentioned two cases that came under his notice. He thought a syphilitic child a most dangerous toy, as those who had lived exemplary lives might contract a disease which was both loathsome and destructive. He thought the disease was not transmitted to the offspring, but mentioned a case where it was thought this was the case, but he thought it might be questioned here whether the real father was the one supposed; he thought it was not satisfactorily decided whether the child would be protected against a secondary contagion, remarking that a great many are exposed to the contagion who do acquire syphilis. He then went on to the treatment, chiefly alluding to the remedies that might be used, their modes of administration, and the time when they might be given. He thought mercury in some form was the best, and might be given by the mouth, or by inunction, and that it should be given as soon as we have evidence of the disease. The child should not be nursed by its mother, but by a wet nurse, she having her breast protected by nipple glasses. He then concluded by saying that they should never say a case is syphilis without being able to give some reason.

Mr. Williams wished to congratulate Mr. Cock, not only for the excellent manner in which he had collected together the known facts on this subject, but also for the original observations he had made. He agreed with him in all he had said, with the exception of one or two minor points; for instance, Mr. Cock had explained away very ingeniously some indications of syphilis, which he would look upon as evidence of that disease. Mr. Williams thought we never need "stain an innocent reputation," if we asked our questions with sufficient care. He did not rely on notched teeth, and asked if arched palate could be taken as an evidence of syphilis. He agreed with Mr. Cock, that it was desirable to treat the child itself, and not through the mother, recommending Hydrarg. c. Creta.

Mr. Metcalf described the symptoms of syphilitic corneitis, pointing out how it should be distinguished from simple corneitis, or panuns due to the irritation of granular lids or trichiasis; and gave his views upon notched teeth, with some original observations upon their prevention.

Mr. Gilbin having read that "the sins of the father shall be visited upon the children," decided that congenital syphilis was an hereditary curse, and remarked that it was easily diagnosed; though, in the case of acquired syphilis, there was more difficulty, because patients would deny the symptoms they had had. He related a testicle case of Mr. Howse's in which there was some difficulty in diagnosis, and also gave his views upon notched teeth.

Mr. Paley thought Mr. Howse's case to be syphilis, because the body of the testicle was involved. He did not think that the irritation of urine, &c., often caused a rash about the genitals of the children, and had heard Dr. Fagge remark, that such cases rarely improved except under syphilitic treatment.

Mr. Turner spoke in reference to the opinion he had understood Mr. Cock to express, that the appearance of a tertiary form of congenital syphilis was associated with the presence of a similar affection in the parent at the time of conception. Any facts ascertained in relation to this would have a most important bearing on the question, whether the so-called tertiary syphilitic symptoms were truly a part of the disease itself, or merely sequelæ due to the state of cachexia resulting from it. He further observed, that the same question occurred in reference to cases in adults, in which characteristic tertiary symptoms appeared without any history or indication of preceding primary or secondary symptoms of the disease. In these cases the question is whether the occurrence of the earlier symptoms has been concealed, or has escaped observation, or whether these later symptoms are the proper phenomena of the disease itself. This difficulty seems to be still further increased, by finding cases presenting early identical features, on the one hand unbenefitted by specific treatments, but quickly recovering under ordinary tonics, and on the other, while obtaining little benefit from the latter treatment, improving rapidly under the other. Two cases of this character have occurred in the Hospital during the last twelve months, both presenting marked syphilitic rupia, but without any history of other symptom of that disease. The first was admitted into Dorcas Ward, and treated then and subsequently in Mary Ward with iodide of potassium and mercury, without any benefit; she was removed to Patience Ward and then recovered rapidly under cod liver oil. The second case was admitted into Mary Ward more recently, and was there treated for a long time on a tonic system, under this she improved considerably up to a certain point, but remained in a stationary condition until specific measures were used, which were followed by rapid and complete recovery. Finally Mr. Turner remarked that he would be very glad if any light could be thrown on the subject.

Mr. Fry described the special characteristic of notched teeth in syphilis. He spoke of the causes of abortion in syphilis, and made some remarks upon the treatment *in utero*. He made some observations upon the period at which the congenital symptoms showed themselves.

Mr. Snook mention some cases, and remarked upon the treatment.

Mr. Paul thought, that the peculiar features in congenital syphilis might depend upon a syphilitic affection of the brain, in the same way that the too early ossification at the base of the skull, interfering with the nutrition of the brain, was supposed to account for the strange deformities of cretius. He did not regard a patient suffering from congenital syphilis, as one in whose blood syphilitic poison circulated—presuming that the fermentative process of a zymotic poison would scarcely extend over two generations; but rather, as labouring under a syphilitic diatheses, in the same way that a strumous diathesis might be inherited. In fact the two diatheses very much resemble one another, in both the tissues were specially liable to become inflamed, in both the inflammation was peculiar, not becoming resolved after the manner of healthy inflammation, but leading, in the one case to caseation, and in the other to the formation of gummata and fibrous tissues. He thought notched teeth might be produced by syhilitic stomatitis affecting their development, and believed many of the patches of so-called fibroid phthisis to be due to syphilis.

Mr. Hetley remarked, that thrush had been given as an evidence of syphilis; surely it was a distinct affection, to which all children were liable, and which was readily cured by borax and glycerine. He recommended that mercury should be used in congenital syphilis, and considered iodide of potassum of little value in such cases.

Mr. Dring observed that syphilitic parents had some children affected with congenital syphilis, while the others might be perfectly healthy. Was this due to the parents being treated? He thought not, but that it rather depended upon the health of the parents at the time that the children were begotten.

Mr. Bingham did not see how children with congenital syphilis could be affected by the mother's milk. He alluded to the development of notched teeth.

Mr. Harsant mentioned a case in which a nurse suckled two babies, one was syphilitic the other healthy, always keeping each to the same breast. The tainted child, probably owing to an abrasion, infected the nurse, causing a chancre; but though she continued to suckle the healthy child, it did not become affected. He did not think that a normal secretion ever carried the poison.

Mr. R. C. Richards related a case, in which a person had become inoculated with syphilis through saliva by a bite. He thought one of the parents must be actually in a state of secondary syphilis, for the disease to be inherited by the child. He did not understand Mr. Cock to describe thrush as a symptom of congenital syphilis, and gave his views upon notched teeth.

Mr. Shadwell described a very interesting case of syphilis, and gave his views upon notched teeth.

Mr. Blackmore gave his views upon notched teeth. He did not think they would be affected by treatment, since they were developed at such an early age.

Mr. McKern asked if the secretions were supposed to be healthy in syphilitic subjects.

The chairman then called upon Mr. Cock to answer the strictures on his paper; after which, Mr. Paul proposed, and Mr. Chicken seconded a vote of thanks to Mr. Cock for his very excellent paper, and the meeting adjourned.

As the following case was referred to at the Physical Society, and many opinions were expressed on the matter, I thought that perhaps the publication of part of this report might elucidate matters.

Your's, &c.,

MARTIEN D. W. LEVIEN.

Patient, æt. 22, clerk, was admitted on September 25th, 1873, under Mr. Howse. Father died of consumption, mother of ovarian tumour. Patient had gonorrhœa four years ago which lasted six weeks, had it again ten months ago with no pain or swelling in testicle, when discharge stopped testicle began to swell and gradually got larger not causing much pain, he then was treated at the Presidency General Hospital, Calcutta, where after one month his scrotum was tapped and a clear yellow fluid drawn off, he remained there five months and was tapped six times, discharged uncured, on the voyage home he received a blow on testicle which caused it to swell and form an abscess, which opened nine days after, and which has remained open ever since.

On admission—Right side of scrotum enlarged swelling 3¼in. in diameter, at its lower part and behind it is irregularly nodulated but in front is a local collection of fluid closely connected with testicle having at its lower part a pin's point opening which on pressure exudes a thin red pus with yellow curds. Plates, left testicle rather large, cord free no thickening.

Treatment—Pot Iodid., 5 gr., Infusi Quasua, 2 oz.

Sept. 27—Gradually improved, collections of fluid in testicle apparently gone.

Oct. 4—Testicle ¼in. smaller, but hard and tense.

Oct. 7—Testicle ¾in. smaller, Pil. Cal. c. Col., 10 gr., s.s.

Oct. 8—Testicle same size. Potass Idod. 7 gr., Infus. Quasua 1 *oz., ter die, till 22nd remained about the same.*

Oct. 22—Testicle 1in. larger, has shooting pains. Mist. Hyd. Perchlor 1 oz., ter die.

Oct. 25—Testicle same size as before the 22nd; there is tense hard swelling (not cord thickening) above testicle, no pain on prepuce.

Nov. 1—Testicle was now normal size. He goes out on Wednesday.

Mr. Howse remarks that this has undoubtedly a syphilitic origin. Patient suffering from chronic inflammation of testicle with caseous deposit.

CLINICAL LECTURE.

REMARKS IN A CASE OF DEATH IN OLD AGE.

By S. O. HABERSHON, M.D.

The first subject that I have to bring before your notice is that of death in old age, when it occurs *without* any organic disease; as in the case of an old man who was brought into Clinical Ward the other day, and died in a few hours. In old age nutrition is deficient, and there is a great loss of reparative power. Vital force—if I may use such a term, an old but still a useful one—in them is lessened. They have less power to resist external influences. Such persons, I say, may die without any organic disease as cancer, apoplexy, gout, rheumatism, prostatic disease, and the like. In them there is a gradual decline of of the physical powers,

they become less and less able to withstand any departure from normal conditions about them, atmospheric or otherwise. If carefully looked after they may die out quietly and slowly; but exposure to cold, or any other such slight cause may lead to almost sudden death. Such was the case with the old man, whose report* I will now read to you.

Patient is a widower, and in comfortable circumstances of life. Yesterday he left his home at Rye Lane, Peckham, about ten o'clock, with the intention of visiting a friend in the City. The weather was quite clear when he left Peckham, but when he got into the fog of London, his breathing became difficult and he got very cold and faint. While on the Royal Exchange, he fell down insensible, and was brought to the Hospital.

On admission—Patient is a fine looking old man with white hair and beard. The capillaries of face are injected, and circulation in them stagnant. He is quite sensible and when asked what he complains of, he says that he has no pain anywhere but feels very cold and weak as though he were going to die. He has very broad arcus senilis though the arteries at wrist and elsewhere feel very elastic and soft. Pupils are fairly dilated; equal, but do not respond to the stimulus of light. Surface of body intensely cold, but the patient does not shiver, pulse 30, full and good. Respirations shallow and catching, 40 in minute. No paralysis of legs, arms, or face. He was put to bed and warmth and stimulants prescribed, but without any effect, and patient died about five o'clock.

An old friend who came to the Hospital with him, said that patient had enjoyed excellent health for the last few years, had never had a similar attack before. He ate a good breakfast before setting out in the cold morning.

On P.M. inspection the only morbid appearances were those in muscular tissue of heart, which was in a state of fibroid degeneration, principally at lower part of septum and of left ventricle. Two encysted gallstones in bladder, kidneys slightly granular.

All, then, that we found in this case at post-mortem was some fibroid degeneration extending into the muscular substance of the heart from the endocardium, with a little thickening of the valves of an atheromatous nature; these are simply senile changes. The kidneys were a little granular, but this was only due to some wasting of the organs, such as occurs in old age. We had here no organic disease, like that which we find after death at an earlier period of life. The old man died simply from the shock produced by coming out into the cold and fog, which though only an inconvenience to us was sufficient to lead to a fatal result in one, whose circulation had become enfeebled, and whose vital force had so nearly lost its power. I am reminded by this case of a instance of longevity, communicated to me by a gentleman the other day; his mother had died at the age of 102, who, during the winter months, "had refused to get up, saying that she was only warm in bed." I have no doubt, it was owing to this uniform warm temperature, that she lived so long; and, I mention the instance as a recommendation to you, when you have to prescribe for old people, to advise that they be kept warm. You should also look carefully after their nourishment. Old people cannot eat large meals, therefore they must take them more frequently. Many old people will wake up about three or four o'clock in the morning, it is a good plan that they should have some nourishment then; otherwise, the interval between their night and morning meals are too long for their declining strength. It is by care in such minutiæ, that we may prolong the life of the aged.

*By H. Williams.

MEDICAL WARDS.

The following report, for which we have to thank Mr. Manser, is one to which we shall have to allude in the continuation of Dr. Habershon's clinical lecture next week—

PLEURITIC EFFUSION.

E. L., æt. 22, was admitted into No. 31, Miriam, on October 25th, 1873, under Dr. Habershon.

Patient's father and mother both living and well: has five brothers and sisters living and healthy. The patient is the eldest of her family; she is married and has two children, her husband is a carpenter. Does nothing but her household work. When about eleven years old she had scarlet fever, otherwise has enjoyed good health. About a fortnight ago, after she had been suffering from a cold, she noticed a pain in her left side, she was short of breath, found a difficulty in getting up stairs, she had no fever or rigors. She went to see a doctor at his own house, but had very little relief. She has not kept her bed up to the time of her admission here, but the last five or six days she has had great difficulty in doing her work in consequence of her shortness of breath. Menstruates regularly.

On admission—She is a moderately well nourished woman, expression not indicative of pain, with a somewhat ruddy complexion (much given to blushing), complains of pain in her left side, at the lower part of the axillary region of the chest, she says she is unable to lie on her right side because her difficulty of breathing then increases so greatly; it hurts her a little to lie on her left side, but she can lie on that side better than the right. Her easiest position is that in which she is now, viz., on her back, somewhat propped up with pillows. She has a slight cough, no expectoration.

Chest inspection—The left side appears bulged at its lower part, and on inspiration appears to move upwards as a whole; pulsation of the heart can be seen distinctly on the right of the sternum. Palpation—There is very slight, if any, expansion of the left side, and there is absence of tactile vibration, though the tactile vibration on the right side is very slight. Percussion—On the right side in front there is a resonance from the clavicle to the third interspace, when the note gets less resonant and runs into dulness which becomes continuous with that of the liver; on the left side in front there is resonance from clavicle to second interspace, when it becomes dull which continues down the whole of that side; behind, on the right side there is hyper-resonance, on the left deficient resonance to opposite the sixth vertebra and dulness below. Auscultation—On the right side puerile breathing, on the left air enters well for the first two interspaces in front, but as you get lower breath sounds get less and less distinct till at the lower part of the chest they are not audible, behind on the left side you can hear breath sounds the whole way down but they are extremely faint and distant at the base, œgophony is well-marked behind on the lower part of the left.

Heart—Pushed over to the right, and its pulsation can be

seen and felt about 1in. to the right of the sternum from the third to the fifth interspaces. No bruit.

Abdomen resonant. Lower part of hypogastric region dull. Liver and spleen dulness normal.

Appetite bad. Tongue moist and clean. Sleeps badly, propped up with pillows. Bowels regular. Urine sp. gr. 1013, clear pale straw color; no albumen. Pulse 108, resp. 24, temp. 99·2 : pulse fair strength, respiration not difficult.

Oct. 27—Pulse 96, resp. 25, temp. 99.

Oct. 28—Dr. Habershon saw her this afternoon, and said there was a rub to be heard just above the left mamma. Emp. Lyttæ 4 by 4 in. lat. sin. Mag. Sulph. dr. i., Mist. Quiniæ oz. i. t. d. s.

Oct. 29—Blister taken well, between two and three ounces of serum withdrawn.

Oct 30—Expresses herself as feeling easier. No rub to be heard above the mamma now, but one distinctly heard beneath it.

Oct. 31—There is resonance now to the third interspace in front, behind the breath sounds are heard more distinctly than before at the base.

Nov. 2—Found her to-night lying on her right side comfortably asleep.

Nov 3—Rub below the left mamma disappeared. Heart's apex can now be felt pulsating in the fifth interspace on the left side internal to the left nipple. On the right side the dulness which commenced in the third interspace, in consequence of the displacement of the heart, has now disappeared and there is only normal liver dulness on the right side.

Nov. 4—Got up this evening for a short time.

The following cases were admitted from Oct. 30 to Nov. 5, 1873.

PETERSHAM.

No new Cases.

PHILIP.

4—Bronchitis and Emphysema
9—Aneurism in Chest
31—Subacute Rheumatism—Musical Systolic Murmur heard at Apex, absent on Inspiration
35—Bronchitis—Asthma
39—Dropsy (?)

STEPHEN

28—Morbus Cordis—Diastolic Aortic Bruit
38—Syphilis
35—Bronchitis—Hæmoptysis (?)—Albuminous Urine
43—Pleurisy with Effusion, right chest
46—Phthisis, left
56—Phthisis

MARY.

17—Phthisis, left upper lobe
26—Ovarian Paracentesis
31—Peri-metritis

ADDISON.

3—Acute Rheumatism
6—Rheumatism
18—Rheumatism
28—Hysteria

JOHN (Clinical).

8—Chorea
10—Facial Paralysis (Syphilis)
13—Nervous Disease
15—Syphilitic Disease of the Brain

MIRIAM) Clinical).

19—Mitral Disease
21—Nephritis
23—Mitral Stenosis—Pleuritic Effusion (left), and Ascites
24—Strain of Ligaments of Neck

SURGICAL WARDS.

—o—

The following cases were admitted from Oct. 30 to Nov. 5, 1873.

ACCIDENT.

3—Fractured Tibia and Fibula
4—Large Scalp Wound
6—Run over, extensive Laceration of Hand and Arm
21—Fractured Tibia
28—Fractured Skull—Operation

CORNELIUS.

1—Injury to Abdomen
5—Concussion
13—Fracture of Tibia and Fibula

LUKE.

2—Burn on Legs
12—Poisoned Wound of Foot

MARTHA

3—Strangulated Hernia—Operation
8—Carcinoma, both Breasts
9—Severe Scalds
16—Carbuncle
22—Compound Comminuted Fracture of right Femur—Death
23—Diseased Hip

LYDIA

17—Disease of Ankle-joint
21—Recurrent Tumour of Upper Jaw

JOB.

5—Acute Synovitis
14—Chronic Synovitis
15—Hip-joint Disease

DORCAS

2—Bursa Patellæ—Operation
5—Old Disease of Femur
11—Nævus—Operation

NAAMAN.

7—Sweep's Cancer

LAZARUS.

6—Phlegmon in Axilla
9—Fractured Fibula
11—Ulcers of Legs
15—Retention of Urine

CHARITY.

14—Varicose Ulcer

BARNABAS (Ophthalmic.)

14—Cataract
16—Accident from Piece of Iron
17—Cerebral Symptoms, with Haziness in Vitreous

RUTH (Ophthalmic.)

No new Cases.

CORRESPONDENCE.

—o—

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents.*]

To the Editor.

Dear Mr. Editor—I am an old man now, but once upon a time I was younger, and now and then I come upon a scrap in my old note books, that I fancy amused me in those days. I can't judge for young people now, but if you think these little pieces fit for a dull corner that by some strange chance might be found in your clever *Gazette*, these and more are quite at your service. To-day I chanced upon the following note which may suit the views of some of our more intellectual young friends if they will read it in an idle hour-supposing such a time is discoverable about Guy's.

I remain, Mr. Editor,

Your's truly,

P. S.

"When I had a little cash in my pockets, and walked along by the shops, it seemed as if I could buy all the nice things one after the other, and the sensation was very enjoyable.

Is it not the same, too, with the little spare intelligence one carries? It seems as if one would with it "get up" all the things that need be known, let alone a lot of shining quotations. But just as the first few purchases open your eyes to the end of your shillings, so when you really try to learn what others around you know so extensively and well, then you find what a little stock of spare intellect you really have about you at any time."

"Here's a melancholy truth! however you work your few ounces of brains, you will get out of them what Thomson and Johnson got with the few pounds their father left them. One pays in gold, another in brains. And the world will sum you up, not by the mite of store your exhaustion was able to give, but by the scrap it was when cast into the world's treasury. They will take you s they find you, and care nothing at all how you got to be what you are. And you, poor fellow, full of the sympathies for your efforts, which your mother and aunt, and sisters and yourself, and all the little circle which saw you up from your petticoats have had for the little swell they have seen you puff, you think it hard of the world; a "hard," "cold," "heartless" world. Yes! It is! Not like your mother, and aunt, and sisters, and sympathising self! But don't be donkey enough to expect it man. Forget your petticoats, and be as hard as the world to your little puff. See how little you think of other little puffing swells."

PILOCEREUS SENILIS.

FOOTBALL CLUB.

—o—

1st. FIFTEEN v. ARAB F.C.

Sir,—This match was played on Wandsworth Common, on Saturday, November 1st. Guy's won easily, two goals one try, to nothing. We won the toss, but there was little or no difference in the choice of goals; the ball was kicked off by our opponents at 4.50, 'twas not long e're we got a touch down: Pearson by a splendid place-kick obtained a goal; the ball being kicked off again, some good scrimmages ensued, we gradually worked the ball up to their goal and got another touch down; the attempt at goal failed, it being an exceedingly difficult try. After some time Maclean got the ball and carried it right through into goal; this time Pearson succeeded in kicking another goal, soon after we made them touch it down, then we changed goals, but the Arabs did not gain any advantage. Welchman caught the ball and had a free kick at goal. The attempt failed, the ball was kept close up their goal until no side was called, when we had obtained five more touch downs in goal. The following Fifteen played:—Captain—W. W. Pinching; backs—Pearson and Robson; half-backs—Maclean, Breach and Gibbs; forwards—Hetley, Rendall, H. Duke, Gilbert, Elliot, Boughton, Wallis, Welchman and Brown.

Your's, &c.,

LUSOR.

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1st. Fifteen *v.* University College Hospital.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

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Guy's Hospital, S.E.
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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

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Guy's Hospital Gazette.

VOL. III.—NO. 7. SATURDAY, NOVEMBER 15, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

OCCASIONALLY a student visits the operating room in the Eye Department. One did the other day, and he was surprised to find that, beyond the dressers he was the only representative of his 314 fellow-students. The remainder of the small assembly was composed of old students, or foreigners, who had come a great distance to witness the skill of our Eye Surgeons. Such an occurrence as this is by no means rare. Even the ophthalmoscope and out-patient rooms are only visited by a few, and we can only suppose that it is through not being aware of the valuable opportunities they are throwing away, that students at this Hospital neglect the ample means offered them for gaining a knowledge of eye diseases. Ample, indeed, when we find that 6,000 out-patients are seen annually, 50 beds continually occupied by eye cases, numerous operations are performed on two days in the week, the use of the ophthalmoscope is taught in the out-patient's department, an unique collection of drawings and preparations referring to the physiology and pathology of the eye is exhibited—and all this with no expense or trouble whatever to them, except the trouble of visiting the out patients' room, the ophthalmoscope room, or the Eye Wards on Tuesday and Friday afternoons.

Practical instances of the indifference of students to the study of eye diseases occur every day. A patient is sent to the Hospital as suffering from cataract, instead of which a large opacity of the cornea is found; a case comes with diagnosis—amaurosis, and proves to be glaucoma in its last stage. A child loses both eyes by purulent ophthalmia, and is sent with staphylomatous eyeballs.

Many similar instances might be quoted, and we may add, that frequently medical men return to the Hospital to learn use of the ophthalmoscope; or to make themselves acquainted with the advance of Ophthalmology, regretting as only too many young men have to do when they enter private practice, and discover too late their lack of knowledge of eye diseases. They will tell you of how much value it would be to them to be able to cure the intolerance of light in a child, to use the ophthalmoscope, &c. Others, again, once assistants in the Eye Department, will inform you that their knowledge of eye diseases has been the key to a rapid advance in their career, and in some instances the sole means of establishing a reputation.

In advising the students to give half an hour once or twice a week to the study of eye diseases, we are simply guided by a knowledge of the service it will be to them in after life. The Eye Wards are much more pleasant without a crowd of students. The few that attend them like to have it all to themselves, and it is much easier for the surgeons to see their patients, or perform their operations, without being constantly questioned, or obliged to repeat continually what to them is very familiar; yet, be assured, they are cheerfully ready to give information, and to discuss subjects which to them must be a labour, but we are sure we may truly say—a labour of love.

ORIGINAL COMMUNICATIONS.

THE VASCULAR CHANGES IN BRIGHT'S DISEASE.

BY A. L. GALABIN, M.A., M.D.

In a review, by which my thesis on the vascular changes in Bright's disease has been honoured in the *Guy's Hospital Gazette* of October 25, are contained some remarks on the account I have given of the waves seen in the normal pulse tracing, which seem to call for a further explanation on my part. This I am the more ready to give because the ques-

tion of the mechanical theory of the pulse, which is a wide and difficult one, was only incidentally referred to in the thesis. I must begin by admitting fully that the criticisms contained in the review appear to me sound in principle, but I think that in relation to one or two of them some other points, which in practice make themselves manifest, have also to be taken into account.

The first point referred to is the evidence that may be derived from the sphygmograph as to arterial tension, and the rule by which inferences are to be guided is here quoted in this shape—that the arterial tension varies directly as the pressure required to call out the largest amplitude of tracing. Now it is quite true that it is generally accepted that the best direct method available for judging of the tension is to take as its measure the pressure required to procure that tracing, which shows the special characters of the pulse most perfectly, and this is usually either that which calls out the greatest amplitude, or one not much exceeding it. But it is not shown that the two quantities are in any exact sense proportional, and the rule stated above can only be accepted with some limitations. Thus, if the tissues covering the artery are thicker or more rigid than usual, a higher pressure is required, because a part of it is spent in overcoming their resistance, and again the methods used to register pressure are open to a little error according to the varying depth at which the artery lies. It is to be remembered, also, that the greatest amplitude in question is not always one of which a tracing can be taken, for some pulses, at a low pressure, have an amplitude which is quite enormous, and defies the capacity of the sphygmograph to represent it. Most sphygmographs indeed are made with a plate which is too narrow to express even a degree of fullness not very excessive. Again, it often happens that the amplitude remains about the same over a somewhat wide range of pressure. In this case the higher limit of pressure is the one to be taken, because to bear a high pressure has more significance than to bear a low one. It is moreover to be considered that the tension to be inferred by the above rule from the recorded pressure is the tension during the intervals of the pulse, and not the maximum tension reached at the acme of the wave. The latter is better shown by the amount of pressure required to suppress the upstroke entirely. In the case of chronic Bright's disease the use of this method shows the maximum, as well as the minimum, tension to be much increased. On the other hand the pulse of aortic regurgitation generally gives its greatest amplitude at quite a low pressure, but yet makes a considerable upstroke under a high pressure. In that case, therefore, the minimum tension is diminished, while the maximum is at the same time increased. It will thus be seen that the direct method of estimating tension is so far open to error that it is desirable to combine with it the indirect method of inferring the tension from the shape of the pulse curve; the latter, however, is at present not fully satisfactory, because physiologists are not yet agreed about the causes of the variation of the several waves.

Next, as to the signs of arterial rigidity. The Reviewer here states quite correctly that, other things being equal, the amplitude is diminished if rigidity be increased, but that this effect may be obviated, if the heart be at the same time hypertrophied. It is necessary, however, to take into consideration another condition, and that is dilatation of the radial artery, which leads to an increase of amplitude. As arteries become rigid with old age, they generally become, at the same time, dilated, and this is one of the reasons why the pulse of atheroma is commonly of greater amplitude than normal. The result is that the signs of arterial rigidity are to be found in the shape of the pulse curve, and not in its amplitude. The same remark applies to a temporary dilatation due to relaxation of muscular fibres. Thus, a relaxed artery gives a fuller pulse, not only because it is more yielding, but because it has become actually larger.

I pass on next to the question of the tidal or first secondary wave, and the explanation which I have given of it, namely, that, owing to acquired velocity in the sphygmograph, the primary or "percussion" wave of the tracing rises to a sharp point, somewhat above the level of the true pulse wave, and that, when the descending curve again meets the true wave, a recoil occurs which checks its descent, and so forms the tidal wave. The tidal wave may be absent, either because the tracing never rises perceptibly above the true pulse, or because the true pulse wave itself falls away so rapidly that the descending line of the tracing never catches it until the bottom of the descent is reached, and any recoil which then occurs, is superposed upon the dicrotic wave, from which, however, it may be slightly separated in hyperdicrotic pulses, and the dicrotic wave then appears as if broken into two. I entirely agree with the Reviewer, that when the tidal wave is equal or superior in height to the primary, it must be inferred that the line of the tracing comes down upon the still rising, and not upon the falling, pulse wave. It is indeed evident that a rebound from a stationary or falling surface could not be higher than the original toss, although one from a rising surface might be. This case, however, is exceptional, and only occurs when arteries are very rigid, or the aortic orifice obstructed. It cannot, therefore, be taken as a universal rule that the tidal wave represents the actual height of the tide in the vessel. This may be seen by a reference to a common form of soft healthy pulse, in which the tidal wave is a small elevation, lower than the dicrotic wave, and therefore *á fortiori* lower than the true primary wave. It might, however, be truly said, that the tidal wave never rises perceptibly higher than the level of the arterial tide.

There is one point on which I am obliged to differ somewhat from the Reviewer, and that is with regard to the first notch, between the primary and tidal waves, for he argues that the fall of the lever, owing to its very slight momentum, could not press down the surface of the vessel so as to cause the trace to fall at that point below the proper wave. I think he has estimated too lightly the momentum of the lever, in judging of it by its weight. The effect of its fall, as tending to produce the dip will be measured by its angular momentum, and this is proportional, not to its weight, but to the product of its weight and the square of its length. Thus, although the weight is very small, the angular momentum will be comparatively somewhat considerable. And the dip of the trace below the true wave may be allowed, by the yielding not only of the vessel, but of the elastic tissues about it, and in some degree also by that of the sphygmograph. Observation shows that the first notch may indent the true wave, for in some cases it falls below the straight line joining the commencement of the upstroke to the top of the tidal wave, as seen in Fig. 15 of the thesis. Probably such indentation is generally very small, but in a diagram it is necessary to exaggerate it for the sake of clearness.

I have spoken of the motions of the lever because it is the lever which immediately describes the trace, but I do not suppose that in general it moves in any way separately from the rest of the instrument, or that anything occurs which could strictly be called a toss. I consider that the deviation of the trace from the true wave is allowed by a slight variation in the degree of indentation of the vessels,

and of the tissues around, and perhaps also in the tension of the spring of the sphygmograph. In some cases, however, when the beat is strong and sudden, the lever is probably literally tossed up, and separated slightly from the knife edge on which it rests.

In answer to the question, which of the two waves most nearly represents the true wave, I consider that each represents a part of it. The primary wave, when separated from the tidal, denotes the steepness of its front, and therefore by inference the initial vigour of the heart's contraction, and this quality is depicted in a magnified form, so that slight differences become manifest, which might escape notice if the true wave were accurately drawn. Thus, what might at first sight seem the imperfection of the sphygmograph becomes practically an advantage. The tidal wave represents the breadth of the true wave, and thus its expansion does actually denote a prolonged flow of blood, and in many cases it will nearly coincide with the corresponding part of the true pulse wave. It is for this reason that I have not objected to retain the term tidal wave, although it was invented to express the theory that the tidal and percussion are two waves travelling from the heart to the periphery with different velocities.

As to the height of the arterial tide, that is indicated by the amplitude of the whole trace, but when, as is usually the case, the primary wave forms its highest point, a certain deduction must be made. There is no means of determining precisely how much this should be, but whether in any given case it is great or small, may be inferred from the shape of the curve. Thus, if the primary wave is high and sharp, followed by a very sudden fall, which is broken only after a long descent by the tidal wave, it may be judged that the first summit has risen considerably above the arterial tide.

As to the signs of arterial rigidity, all observers are in happy agreement. They consist in the presence of a tidal wave, not only considerable, but occurring high up in the descending curve, and when rigidity is extreme, this becomes widely expanded. A similar form of curve may however result from hypertrophy of heart combined with aortic obstruction, and thus the testimony of the sphygmograph must be checked by other modes of observation.

The small wave which may follow the dicrotic is generally an oscillatory wave, resembling the tidal in its origin. But in pulses having no tidal wave there is sometimes seen, at a considerable interval after the dicrotic, a third well-marked wave, which undoubtedly really occurs in the artery, and which may be called the tricrotic wave. Such a curve implies a very low arterial tension, combined with a rather slow pulse. I have lately met with it rather frequently, sometimes, I regret to say, in the pulses of my friends. Possibly it may be in some cases the effect of chronic nicotism. I have also found it in mitral disease, in phthisis, and in the intervals of the fits of ague. A curve of this kind may somewhat resemble one form of the commoner tricrotic pulse, in which the second wave is the tidal wave, but it may at once be distinguished from it by its low tension, as opposed to the high tension of the other. As to the cause of the dicrotic and tricrotic waves, I must refer to a paper in the "Journal of Anatomy and Physiology" for the present month.

THE BLOOD,

BY HENRY ASHBY.

The blood has been described as a liquid tissue, though in a strict sense this is not correct, as it holds in suspension certain solid matter. This consists of little masses of protoplasm—the blood corpuscles.

The offices fulfilled by the blood are obviously important. The liquor sanguinis or liquid portion bestows on blood its properties of fluidity, holds in solution its crystalloid constituents and the elements of a plastic substance, the formation of which tends to staunch any leakage in its channels, and by its effusion prepares the way for repair.

The corpuscles carry the oxygen for the necessary combustion to the remotest parts of the system, supply the motor power to the contracting muscle, and material for the reformation of the worn out or damaged cells, which form an integral part of the different tissues.

The blood is a thick consistent liquid of saltish taste and alkaline reaction, its specific gravity varies from 1050—1060. The specific gravity of the liquor sanguinis and corpuscles bears a different relation in various animals. —In the Horse the specific gravity of the corpuscles is 1105, (Hoppe Seyler) and the liq. sanguinis 1028, the difference being somewhat more considerable than in other animals. One of the most striking characteristics of the blood is its coagulability. If blood be drawn from the vessel of a living or recently dead animal, it will be seen that the coagulum involves the red coloring matter, and a straw colored liquid, the serum, is left. If the blood be received into a capillary tube or on a slip of glass and examined by the microscope, it will be seen, that fibrin retains the corpuscles with the exception of some of the white which swim in the serum.

THE RED BLOOD DISCS.

Following shortly after the discovery of the circulation of the blood by Harvey in 1619, Swammerdam described the corpuscles in the blood of the frog in 1658, Malpighi in the hedgehog in 1661, and Leeuwenhoek in man in 1673. Since that day their structure and constitution have been the subject of much controversy and cannot be said to be definitely settled in our own day. There are two types of red blook discs found among the vertebrata—the circular and elliptical. The circular are found in mammals, except the camel and auchenia. In the latter and in birds, amphibia and most fishes (except cyclostomata) they are elliptical.

In the circular form they are of nearly equal size, and when viewed edgeways they present rounded ends and slightly hollowed surfaces,—they are smooth and their substance homogeneous.—In that position in which their outhine is most distinct, the centre appears lighter than the outer portion, the extreme edge presenting a clear ring. In birds, amphibia and fishes the view edgeways is different —near the centre of the long axis is a rounded projection which appears whiter than the rest. This correspond to the nuclens of other elements and has no analogue in the blood discs of mammals.

Their size bears no definite relation to the size of the animal. In man, the dog and the rabbit they are nearly the same size $\frac{1}{3500}$in.; in the horse, ox, ass, cat, mouse and bat they are about the same size and slightly smaller than in man $\frac{1}{4500}$in.; in the sheep and goat, they are still smaller $\frac{1}{6000}$in., (A. S. Taylor). Among the largest is the proteus, and the smallest those of the moschus. With regard to their number, it has been estimated that there are 5,000,000 corpuscles in a cubic millimeter (millimeter=$\frac{1}{25}$in.) of blood. In one hundred volumns of blood, there would be 36 of corpuscles and 64 of plasma. (Vierordt).

Another phenomenon observed by the microscope, is the

tendency the corpuscles exhibit, when the blood is drawn from the vessels or under certain inflammatory changes within, to arrange themselves in rouleaux like a pile of coins. This phenomenon was first described by the late Mr. Lister and Dr. Hodgkin, of Guy's Hospital.

It has received since that time many and varied explanations, some attributing it to some "vital" attraction, others more reasonably to the operation of physical laws.

Prof. Lister, of Edinburgh, has attempted to explain it by assuming, that the corpuscles removed from the body possess a certain degree of mutual adhesiveness, which maintains them in rouleaux when brought together by accidental circumstances. He does not believe in the existence of any mutual attraction. More satisfactory, because capable more or less of actual demonstration, is the theory of Dr. Norris. To illustrate his views, small discs may be punched out of thin sheet cork by a borer $\frac{1}{4}$in. in diameter. These may be variously weighted by one or two small shots, so that when placed in water they float or are suspended in the water edge upwards and downwards, it will be observed that those which float partly out of the water show a tendency to aggregate together, while those entirely submerged exhibit no such tendency. The former are attracted together in obedience to the well-known laws of capillarity (see Deschanel, Nat. Philos., p. 136). But it is evident no such conditions are present in the blood corpuscles as they are entirely submerged. If now a handful of the discs be taken out of the water and thrown into a beaker containing oil of turpentine, some will probably sink and some float, but they will all at once in a most decided manner arrange themselves in rouleaux, after the manner of blood-corpuscles. Turpentine is a liquid immiscible with water. The molecules of water exerts mutual attraction towards one another, and a repulsion towards the molecules of turpentine.

The same phenomenon is witnessed between any two immiscible or indifferent liquid as chloroform and water, petroleum and water. The drops of water adhering to the discs exert an attraction for one another, and for the cork and a repulsion for the turpentine, and the result, whenby accident they are brought near one another, is that they adhere in rouleaux.

For the application of this phenomenon to the corpuscles of the blood, it may be assumed that under the influence of irritation within the vessel or of contact with foreign matter without, an exosmotic current is established, and the surface of the corpuscles becomes wetted with their contained matter, which is indifferent to or immiscible with the liq. sanguinis, and then aggregation together like the cork discs ensues. This explanation, though consisting partly of theory, is the most satisfactory yet brought forward.

(*To be continued*).

CLINICAL LECTURE.

—o—

REMARKS ON CASES OF PLEURITIC EFFUSION.

BY S. O. HABERSHON, M.D.

We are fortunate in having several cases of pleuritic effusion in the Wards at the same time, which serve to distinguish some of the chief varieties of pleurisy, and I take advantage of them to illustrate to you some remarks upon this disease. These varieties are by no means similar. They run a different course, and require a different line of treatment. We have in the first place a *simple pleuritis*, such as is liable to follow exposure to cold. This, if it occur in strong healthy people, is a favourable form of the disease, one that tends naturally towards recovery; but if, on the other hand, the patient happen to be of a weak constitution, or tuberculous, the effused material is apt to become corpuscular, leading to empyema, and recovery is protracted; if indeed, the patient should recover at all. Next, we have a purely *passive effusion*, as in the case of mitral stenosis in No. 23 bed, where the effusion is due simply to congestion of the pleura, the result of impeded circulation. Then there is *rheumatic effusion*, a form of pleurisy occurring in cases of acute rheumatism. The effusion here takes place into the pleura, in the same way that it does into the joint, and requires no special treatment beyond that used for the general affection, with which it usually subsides. *Diaphragmatic pleurisy* is a severe form, which you should be able to recognise. I shall speak further of it when we come to the symptoms. It consists of a pleurisy which commences on the diaphragm. There is also a variety which depends upon *alterated blood*, as in pyæmia or some cases of Bright's disease. Then inflammation may spread by continuity as in cases of pneumonia; or we may have *mechanical pleurisy* from broken ribs. Here it is necessary to keep the ribs quiet with a bandage, which will relieve the pain, and the irritation of the pleura. Lastly, there is a form called *latent pleurisy* in which effusion, often to great extent, takes place without the knowledge of the patient, until it gives rise to dyspnœa by pressing on the lungs. There is no pain, and the only evidences of fluid in the chest are the marked physical signs, which are always present.

The forms of pleurisy are then—1. Simple inflammation of the pleura; 2. Empyema; 3. Passive effusion; 4. Rheumatic effusion; 5. Diaphragmatic pleurisy; 6. Pleurisy from altered blood; 7. Pleurisy form contact with inflamed lung; 8. Mechanical Pleurisy; and 9. Latent pleurisy.

Before discussing the symptoms, I will read to you the report of two marked cases of simple pleurisy and one of empyema. I fear there will not be time to read those of the heart cases with passive effusion, or of the Rheumatic pleurisy. The first case is that of a woman, æt. 22, admitted into No. 31, Clinical Ward, which was given in our last issue.

Here is a case of simple pleurisy, evidently improving, for the rub is heard lower every day, showing that the effusion is becoming absorbed, and the pleural surfaces are coming in contact as the fluid disappears.

The next case* is that of S. J., æt. 38, who was admitted into No. 20, Clinical Ward, on October 21, 1873. Mother and a brother died of Phthisis, husband died of rheumatism, has had 10 children, all died young.

Patient is a general servant. Had scarlatina twelve years ago, rheumatic fever seven years ago. Nine months ago suffered from severe pains in left side just below the nipple, which lasted only a short time. Present illness—About ten weeks ago, she suffered severe shooting pains near the left nipple accompanied by shortness of breath, obliging her to keep her bed. For three months has had abscesses in different parts of the body, especially on her hands.

On admission—Well nourished woman, lies on her back, and says the pain is increased, and the breathing rendered

* By Mr. H. Williams.

difficult by lying on her side, especially on her right side. Breath short 36, no distress, tongue clear, bowels regular, skin hot and dry, loss of appetite. Abdomen, liver and spleen normal. Heart's apex cannot be defined but impulse is felt just on the right of sternum, sounds normal. Lungs. —*Anterior, percussion—resonance good on right side*, and on the left to the second rib below this dulness is absolute, dulness extends to right border of sternum. Auscultation —On right side breathing is puerile, on left side breathing is indistinct to second rib and accompanied by slight crepitation, below this sounds are scarcely heard. Voice has a distinct twang near the nipple. Posterior, Percussion—Right side is almost hyper-resonant, left side is resonant to spine of scapula, below this is quite dull. Auscultation—On right side puerile breathing, on left side there is scarcely audible breathing with crepitation at the apex, below margin of dulness no breath sounds are heard. Œgophony at angle of scapula, tactile vibration is absent on the left side, and but faint on the right side. Left side bulges and moves but slightly with respiration. Measured at ensiform cartilage right side is 14½in., left side is 15½in. Pulse 106 small, temp. 98·2. Urine sp. gr. 1008, faint trace of albumen. To have Pot. Iodid. 5 gr., Mist. Camph. 2 oz., t. d. s. Emp. Lyttæ pro lat. sinist. Middle diet.

Oct. 22—Slept well, slight cough, no expectoration, sibilus on right side.

Oct. 24—Fluid completely fills the left side. Breathing is tubular near the nipple. To have Pot. Acet. 1 dr., Mist. Pot. Nit 2 oz., t. d. s.

Oct. 27—Rhonchus and sibilus on right side. Cough very troublesome, expectoration viscid and frothy.

Oct. 29—Bronchitic sounds less marked, heard slightly left side also. To have Emp. Lyttæ. Albumen still present in urine

Oct. 31—Much better, expectoration less.

Nov. 3—Very faint, crepitation above left clavicle.

Nov. 5—Right chest appears quite free, breathing is heard at left apex.

The patient here has phthisis in her family history, and this is sufficient to account for her not progressing so favourably as the other case; moreover, owing to the cold weather, she has some bronchitis of the other lung. We may have to tap the chest to free the compressed lung, if the bronchitis incapacitate the other.

The third case† I have to read to you is thst of a man, æt. 39, who was admitted into No. 3, Clinical Ward, on October 24, 1873.

Patient has had cough, and lost flesh for six months. No expectoration nor night sweats. A fortnight ago he had pleuritic pain in left side, and he gave up work five days before admission. He is a hatter, works in a hot close room, and has drunk five or six pints of beer daily. Father died of phthisis. No previous illness.

On admission—Patient has an anxious expression, and his respiration is laboured and quick. Complains of dull aching pain over left chest, cough with sputum, anorexia and languor. He is slightly delirious. Temp. 100·4, pulse 116, resp. 32. In the evening he sweated profusely. Inspection of chest showed that left side with exception of extreme apex was motionless in respiration, percussion was absolutely dull everywhere except at apex. Stomach distended. Auscultation gave puerile breathing at apex corresponding with resonance, below there was bronchial breathing, bronchophony and moist sounds, loss of tactile vibration at base in front and behind. On right side respiration was puerile and coarse. Heart normal, liver enlarged. Urine sp. gr. 1010, no albumen; no deficiency of chlorides.

Oct. 28—Evening—Patient's dyspnœa is very urgent and his face somewhat livid, he lies altogether on his right side. Resp. 40, sweating profusely. On right side there are to be heard rhonchi and sibili with rales large and small, no dulness. Temp. 90·6.

Oct. 28—Dyspnœa more urgent, 52 in minute. Face is very dusky, rales in throat. Died at 5 p.m.

(To be concluded in our next).

† By Mr. Farrant Fry.

MEDICAL WARDS.

The following cases were admitted from Nov. 6 to Nov. 12, 1873.

BRIGHT (PETERSHAM).

5—Acute Rheumatism
12—Acnte Rheumatism
13—Paraplegia

PHILIP.

10—Morbus Cordis—Aortic
17—Intra-thoracic Tumour—Lymphoma?
23—Bright's Disease
33—Subacute Rheumatism

STEPHEN

10—Bronchitis
17—Typhoid?
22—Bronchitis
30—Phthisis
33—Locomotor Ataxia?
39—Gout
47—Ascites and Pleuritic Effusion

MARY.

11—Albuminuria
13—Phthisis
15—Zona
21—Morbus Cordis

ADDISON.

11—Acute Rheumatism
24—Broncho-pneumonia
33—Syphilis
37—Renal Colic?

JOHN (Clinical).

1—Abdominal Aneurism
2—Morbus Cordis, Aortic
4—Pneumonia
10—Acute Rheumatism
12—Syphilitic Laryngitis
13—Sclerosis of Spinal Cord

MIRIAM (Clinical).

18—Abdominal Tumour (Displaced Kidney?)
22—Ascites
33—Croup

SURGICAL WARDS.

The following cases were admitted from Nov 6 to Nov. 12, 1873.

ACCIDENT.

9—Contused Foot
16—Concussion of Brain
12—Scald
23—Fractured Tibia and Fibula

CORNELIUS.

1—Contusion of Abdomen
5—Severe Injury of Lung—Death
7—Contusions
11—Cut throat
13—Fracture of Tibia and Fibula
15—Concussion of Brain

LYDIA

12—Fistula of Rectum

MARTHA

8—Ulcer of Leg

NAAMAN.

2—Hip-joint Disease, right
13—Periostitis of Tibia
15—Epithelioma of Cheek ?
21—Disease of Knee-joint
22—Disease of Sup. Maxilla

LAZARUS.

9—Tumour of Groin
15—Necrosis of Great Toe
22—Fistula of Rectum

JOB.

2—Necrosis of Head of Tibia
18—Epithelioma of Tongue
23—Fistula in Perineo (Urinary ?)

LUKE.

1—Concussion of Brain
7—Internal Hæmorrhoids
11—Ulceration with Eczema of Leg
13—Retention of Urine
17—Buborocele
18—Abscess
19—Necrosis of Jaw

DORCAS

No new Cases.

CHARITY.

4—Contused Hip
5—Tumour of Face (Enchondroma—Operation)
11—Contusions
16—Fractured Tibia and Fibul
17—Strangulated Femoral Hernia—Operation
25—Cicatrices after Burn

CORRESPONDENCE.

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents.*]

ELECTROLYTIC TREATMENT OF WOUNDS.

To the Editor.

Sir,—The following facts in reference to Case 3, quoted by Mr. Golding-Bird, in his excellent paper on the electrolytic treatment of wounds, may possibly interest some of your readers.

The granulations over which the electrodes, both positive and negative were placed, have now, November 10, completely skinned over.

An additional point of interest is the condition of that skin which differs from that developed under the carbolic oil treatment in being thicker, firmer, and both to the eye and the touch, perceptibly elevated.

Is not this an additional argument, were one needed, to negative the assumption that mere mechanical pressure is the only element in the production of the good results he obtained; and in favour of the stimulating result of the chemical decomposition, as shown in the reactions of the deposited mucus and the disintegration of the negative plate, being a real and important factor?

I am, Sir,
Yours, &c.,
W. E. PALEY.

MEDICAL MICROSCOPICAL SOCIETY.

To the Editor.

Sir,—The first ordinary meeting of the Medical Microscopical Society will be held on Friday, November 21st, at the Royal Westminster Ophthalmic Hospital, Charing-cross, at 8 p.m. There will be no paper read, but specimens will be exhibited. Slides relating to the subject of Inflammation have been specially promised.

Members are reminded that their subscriptions for the ensuing year are now due; and that they can be paid either on the night of meeting, or forwarded to the treasurer, T. C. White, Esq., 32, Belgrave Road, Pimlico, S.W.

C. H. GOLDING BIRD,
Hon. Sec.

Nov. 11, 1873.

BIRTH.—On the 12th inst., the wife of the Rev. Philip Swatman, Chaplain of Guy's Hospital, of a daughter.

APOTHECARIES' HALL.—At a Court held on Thursday, Nov. 13, Mr. W. M. Jones, of Guy's Hospital, passed his primary professional examination.

BIBLE CLASS.—The next meeting of the Students' Bible Class will be held on Tuesday next, the 18th inst., at 6.30 p.m., at Hibernia Chambers, London Bridge. Subject—John v. 17.30.

PHYSICAL SOCIETY.—The next meeting of this society will be held this evening, at 7.30, when Mr. Paul will read a paper, entitled, "What relation does Tubercle bear to Phthisis?" Mr. Golding Bird will be in the chair. Several microscopic specimens will be shown a quarter of an hour before the meeting commences.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

ANSWERS TO CORRESPONDENTS.

Secretary of the Royal College of Surgeons in Ireland—We will attend to your request at our earliest opportunity.

Pilocereus Senilis, A., W. W., C. H. Golding Bird—We are sorry that want of space forces us to delay your valuable communications until our next issue.

W. P. Mallam is thanked.

B. Gowing is thanked.

— Aspland is thanked.

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All communications to be addressed to

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"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER at 104 Borough High-street, Southwark, Surrey.—Saturday Nov. 15, 1873

Guy's Hospital Gazette.

VOL. III.—NO. 8. SATURDAY, NOVEMBER 22, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

FOOTBALL has for many years been the most favourite atletic sport at Guy's. While the Cricket and Boat Clubs have struggled out a miserable existence, Football has always flourished. Last year, owing to a variety of unfavourable circumstances, the Club was not quite so successful as usual, but this year there has been a strong reaction; all the old men are playing again and we have some good additions from the first year's men, the consequence being a very strong team. Our forwards are much heavier than usual and play well together; our two half-backs seem to have wonderfully improved since last year, a very noticeable feature in their play being the way they pass the ball one to another; while one, at least, of our backs is a player of whom any Club might be proud. Only four matches have yet been played by the first fifteen, one (with St. Thomas's) having been given up owing to their inability to get up a team.

Of these four matches we have won three with the greatest ease, and the fourth (with University College) was drawn in our favour. This match indeed was the only one where the mettle of our men has been tried at all, it was played at Victoria Park a fortnight ago, and resulted in our getting one goal, one try at goal and one touch down against one goal and three touch downs, the balance thus being favourable to us, notwithstanding the statements put forth by some of the University men, that it was in their favour. It is greatly to be regretted that our list of matches this year should comprise so many poor ones, we hope that next year our energetic secretary will strike out two at least of those that have already been played, and endeavour instead to arrange matches with clubs, like Richmond and the Marlborough Nomads. Next Saturday we are to play the Clapham Rovers, and they will no doubt give our men some work to do.

We are glad to notice that at every match this year, the full team of fifteen have turned up on the ground, this being a great improvement over last year when it was not at all uncommon for ten or twelve only to appear at the last moment, we hope that this may continue all through the season even if the day should happen to be wet which it fortunately has not been once this year. We have one more remark to make. It is greatly to be hoped, that next year a match may be arranged with St. Bartholomew's. We meet them at Cricket and at the united hospital sports, and find them very honourable opponents, and there is no reason why they should not be equally so at Football; it seems to us very childish for Guy's men to perpetuate an old quarrel (which after all was no quarrel at all), and refuse to accept such a challenge as that which they so cordially sent us this year.

ORIGINAL COMMUNICATIONS.

THE BLOOD,

BY HENRY ASHBY.

Notwithstanding the numerous observations accumulated respecting the red corpuscle, there is still a great deal of uncertainty concerning their origin, structure and final destination. Compared with the other elements of the tissues, they are so readily alterable by the action of re-agents, and by various external influences, and the difficulty of observing them under normal conditions is so great, that up to the present time, there exists no certainty as to their exact structure.

The description given by Gulliver has done duty on many occasions. He describes the red blood disc as consisting of two parts—a tegumentary membranous frame of a homogeneous structureless substance containing a semifluid

viscid coloured matter. But no investing membrane could be satisfactorily demonstrated, and the shape of the red corpuscle with its concave sides is opposed to the idea of a vesicle filled with fluid.

The modern view upheld by Brücke and Stricker, considers the corpuscle to consist of 1. A non-contractile soft colourless transparent porous substance; and 2. A central part of forming the neucleus of a neucleated corpuscle, and a coloured crystallizable mass. *Hæmoglobin*—This latter substance fills the intermediate spaces of the porous mass, and thus with it makes one continuous whole.

To the colourless mass, Brücke has given the name of *œcoid*, and the coloured matter the *zooid*.

These views are founded on changes observed in the corpuscles, after subjecting them to the action of certain reagents as boracic acid, carbonic acid, &c.

Blood is taken from the tail of a newt, and is treated to ½ per cent. salt solution, the red corpuscles after awhile become corrugated or star-shaped. They are then irrigated with a 2 per cent. solution of boracic acid; it will then be seen that the corpuscles become paler, the neucleus larger and more coloured. The yellow central portion (the zooid) become eccentric in position, and is sometimes extruded from the pale disc (œcoid).

Brücke believes that this zooid withdraws itself from the pale disc, and forms an independent existence. Rollett and Klein believe these phenomena to be due to a kind of coagulation.

THE COLOURLESS CORPUSCLES.

If a drop of blood be taken from a living newt, placed on a glass slide and covered with a thin glass, and protected from evaporation by surrounding it with oil, the white corpuscles will be under favourable circumstances for being observed. In the first place it will be noticed that they are far less numerous than the red, and many of them exhibit a tendency to stick to the glass, while the red float freely about.

Care must be taken not to mistake the free neuclei of the red corpuscle, which are often extruded in consequence of pressure for white corpuscles.

It will be further observed, that these little masses, at first uniform, gradually extend irregular processes, till their surface are beset with appendages of various lengths. It will also be noticed that they often increase in size, while exhibiting these movements. It will be seen if a high enormous power is used, that some parts of their substance are hyaline, and that some of them contain clear spots with a defined contour. These are the *vacuoles*, and consist of spaces filled with fluid.

Besides these vacuoles, there are one or more bodies of roundish or irregular form containing granules, these are the *neuclei*. In addition to the common colourless corpuscle, there are others less numerous containing dark granules, which likewise exhibit amœboid movements. There are also small bodies resembling neuclei. The addition of acid bring out the neuclei of the corpuscles, and render the remaining substance transparent. With regard to the number of the white corpuscles, they are far less numerous than the red, being in proportion of 1 to 335, (Welcker). They are more numerous in the splenic and hepatic veins; being according to Hirt, 1 to 60 in the splenic, and 1 to 170 in the hepatic.

The origin of the white corpuscles, is an unsettled question. It is certain that large numbers of them are constantly being added to the blood by the agency of the lymph stream, and that these undergo multiplication by fissure in the adenoid tissues of the body. Their destination is probably to the reinforce the number of the red corpuscles. Transitional forms have been described by Von Recklinghausen, who has noticed active cell-formation in the blood of the frog exposed to moist air, and which lead ultimately to the formation of red corpuscles.

Since the observations of Cohnheim on the migration of blood corpuscles, it is clear that the regeneration of the tissues generally is one of the offices fulfilled by the white corpuscles. One sees in the exposed mesentery of the frog the corpuscles clinging to the inner wall of the small vessels, then a process passes through the wall, followed by the whole substance of the cell. Aided by their amœboid movements they wander in the direction of any irritation.

Here they accumulate and form by their accumulations, the formative tissue necessary for repair. Their final destination may be as a pus corpuscle or a formed element, as an epithelial cell.

The destination of the coloured corpuscle is a mystery. Some, without any very good reason, regard the spleen as their grave.

From the connection observed between the colouring matter of the bile and blood, Kuhne believes that the secretions of bile is accompanied by a destruction of red corpuscles. They are probably also undergoing destruction in the contracting muscle, and other active tissues of the body.

(To be continued).

CONSUMPTION!!

(Of Alcoholic Stimulant.)

(Compare line for line with the original.)

Lines suggested by a perusal of a beautiful ode, appearing in a recent number, entitled "*Phthisis*," by *X.*, with an attempt at the same *x*-quisite metre.

This is that dread *D. T.* that stays,
With certain, though with shaking hand,
The tipplers who "grog-blossom" here,
In England's homes—our public-house (round the corner)-land.*

Favoured by more drinking people,
Than any other country-on-the-face-of the earth,
Who ever lived to stir the glass,
And give way to the most uproarious and (we think) reprehensible mirth.

But infested by this dread pest,
Which makes the brain to reel and whirl,
As glass after glass is most-foolishly (and-recklessly) tossed off
By "*topers*" at their "*early pearl*."†

The female—nothing next her skin
But draggled skirt, in frost and snow,
Whilst on her scrubby pimpled cheeks
And nose THE freshest "*blossoms*" grow.

Her form is *anything* but slim,
Her hair in tangled knots doth twine,
And beneath the-particularly-repulsive-and-scowling lashes
Eyes looking ready for a "*shine*."

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* For this line, and certain others which follow, we claim a poet's (!), or rather a public-house license, under a new act.

† This is a pun—"*Topaz*" and "*purl*." Ha! ha!

Such fall down on every side,
In very-nearly-every-gutter in the land ·
Yet the whole-of-the-combined-medical-talent-of-Guy's cannot tell us
How we may stay its ruthless hand.

Such was the case of one I knew.
But she's "*locked up*"—can't say I grieve,
When I muse on her giant strength,
And the Dickens own *thrashing* I *used* to receive.

DOUBLE X.—TREBLE X., IF YOU LIKE.

CLINICAL LECTURE.

REMARKS ON CASES OF PLEURITIC EFFUSION.

BY S. O. HABERSHON, M.D.

(*Continued from page* 53.)

Having read to you the reports of the cases, I wil proceed to recapitulate the symptoms systematically. 1. In reference to the *Temperature*. In pleurisy it is not usual to have much febrile disturbance; in some cases the effusion takes place with scarcely any elevation of temperature, in others it may rise to 102 dg. or 103 dg., but never to the height that pneumonia reaches: 2. *Pain* is a prominent symptom, it is of a sharp, stabbing character, and occurs with the breathing, when the pleural surfaces are rubbed one against the other. In the diaphragmatic form it is the main symptom by which we form our diagnosis; the peculiar *severity* of this sharp cutting pain with respiration; 3. *Dry cough*, you will usually notice, that patients with pleuritic effusion have a hacking cough without expectoration; 4. *Position*, they cannot lie on the side opposite the effusion, for the gravitation of the fluid presses on and interferes with the proper action of the heart and the healthy lung. But, more usually than lying on the affected side, they prefer to lie *towards* it, being supported with pillows, and keeping the ribs as quiet as possible; 5. *Shortness of breath* is a frequent symptom, and depends upon either the quantity of the effusion, or complication with bronchitis; the latter, especially, tends to make the case more severe. These are the general symptoms of the disease, we will now pass on to consider the physical signs.—1. *Diminished mobility*, in the first stage from the pain caused by each inspiration effect; and later on, in the stage of effusion, because the pleura on that side is filled with fluid. If you bare the chest, you will at once observe, that while the healthy side moves freely, the affected side remains fixed; at first, I say, by the pain, and later on by the fluid. —2. *Friction sound*, called the "pleuritic rub," is heard as a harsh, rubbing sound caused by the two surfaces of the pleura coated with lymph rubbing together. Of course it is not heard where they are separated by fluid; but when the fluid is in small quantity, it is heard at the end of inspiration; when great, you hear it often above the fluid, getting lower as the fluid becomes absorbed. In diaphragmatic pleurisy no rub is heard till the pleura costales becomes involved. 3. *Percussion sound*, is distinguished from that of pneumonia or solid growths by being duller. If only a little fluid, the dulness varies with gravitation; if much, it does not alter. 4. *Tubular breathing*, at first, when the effusion is slight, the tubes remain open, while the air-cells are compressed, at this stage tubular breathing occurs; but when the effusion increases, the pressure closes the tubes as well, and no respiratory sound can be heard. So with slight effusion there is bronchial breathing; with much, none at all. 5. *Voice sounds* also depends upon the amount of compression of the lung; if slight, we get œgophony, if a little more, bronchial œgophony, and beyond that none at all. 6. *Absence of tactile vibration*—While in pneumonia it is increased, in pleurisy it is lessened, or with much effusion altogether lost. You must bear in mind, that another sign of pleurisy, feeble voice, may be a source of fallacy. 7. *Filling up of the intercostal spaces*—The effusion causes the spaces to become on a level with the ribs, so that the affected side appears quite plain; or in some cases the spaces bulge, especially where the effusion has become purulent. 8. *Displacement of Viscera*—The heart is often pushed quite over to the other side of the chest. The liver or spleen may be pushed downwards, or pressure on the œsophagus may cause dysphagia. 9. *Metallic sounds in stomach* sometimes occur, and depend upon the close proximity of a distended stomach to consolidated lung. It was from this sign, that I was led to expect some consolidation in the third case I read to you. This metallic sound occurs also in pneumothorax.

In my experience pleurisy occurs much more frequently on the left, than the right side. As a source of fallacy I would mention to you, that a tag of lung, adherent from old pleurisy to the chest wall, in the middle of a recent effusion leads to loud bronchial breathing with resonance, difficult to understand. I have also known very large effusion into the pericardium give rise to the signs of pleuritic effusion. Solid tumours, such as cancers, are more likely to be mistaken for pneumonia than fluid, since they lead to marked tactile vibration.

In the diagnosis the amount of chlorides in the urine may help in deciding as to any complication with pneumonia; in pleurisy they remain as usual, while in pneumonia, as you are aware, they are diminished or disappear altogether

Prognosis—A simple case of pleurisy with good history usually gets well; but with phthisis in the family, or complicated with pneumonia or bad kidneys, the prognosis becomes more grave.

Treatment—Some books recommend bleeding; but I would strongly urge you not to practice it. In some cases, where the lung is injured and the heart gorged with blood, there may be necessity for it, but not otherwise. If the effusion be great enough to impede the circulation, it is better to put a trochar in, and draw it off. It would perhaps have been better to have done so in the case of empyema, but it is a question whether the fluid would have run out. If the pain be extremely severe, you may use cupping glasses, or keep the chest warm with a large poultice or a flannel roller; or you may apply chloroform and belladonna liniment on spongio piline. Act on the bowels; cathartics tend to relieve the effusion; and if there be any feverishness, then use salines, the acetate of ammonia or citrate of potash. The iodide of potassium does not suit in acute cases. If severe pain, use morphia or opium, just sufficient to allay it, not enough to narcotise. Mercury is an unnecessary and an injurious remedy, in weak patients it tends to increase the fluid. I remember a weakly lad, treated in the old way with calomel, antimony, and opium; the effusion was steadily increasing, till the treatment was changed to quinine and nourishing diet, when the effusion at once began to be re-absorbed. Another good remedy is a blister, and if the patient be weak give quinine. In very chronic cases change of air is often followed by marked benefit, but great

care must be taken to protect from cold, for an attack of bronchitis might be fatal.

I had intended to speak of the changes which occur as the fluid becomes absorbed, but time only permits me to mention that, while on the one hand the lung expands to fill the vacunm, often leading to dilatation of the tubes, which has been mistaken for phthisis; on the other the ribs may fall in, and the chest become flattened on that side, and often the spine distorted; so much so in fact, that it has been mistaken for spinal disease.

PHYSICAL SOCIETY.

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The fourth meeting of the society, this session, was held last Saturday evening, at half-past seven, at which the Treasurer of the Hospital was present. Mr. Golding Bird occupied the chair, and Mr. Paul read a paper entitled "What relation does Tubercle bear to Phthisis." Mr. Paul, in commencement, remarked that, though he did not wish at all to enter into the history of tubercle, he must at least go back to the time of Addison; whose views on phthisis he described, showing how much of the so-called "Niemeyer's views" was simply a repetition of what had been taught here thirty years ago. The chief difference being that, while Addison looked upon tubercle in his tuberclo-pneumonic phthisis only as a further evidence of the strumous diathesis, which had led to the non-resolution of the pneumonic products, Niemeyer considered them due to the theory of infection. Which theory Mr. Paul only accepted as far as absorption by the blood vessels was concerned, objecting to the application of the experiments of Villemin, Burdon Sanderson, Wilson Fox, Cohnheim and others to a lymphatic absorption, restricted to the lung. He showed the great difficulties with which Addison had to contend, and mentioned some of the chief changes of opinion in the history of tubercle, from his time up to the recent debate at the Pathological Society. He described the histology, origin, and distribution of the structures called tubercle. He then endeavoured to show, that Dr. Wilson Fox, and those who agreed with him had not argued on a sound basis, when they accepted the appearances found in the lungs of children dead of acute tuberculosis, such as caseations, cavities, infiltrations, &c., as tubercular; and by this endeavoured to prove, that similar appearances in phthisis must therefore be tubercular also. Mr. Paul considered such conditions, in the case of the childrens lungs, as resulting from inflammatory conditions arouud the original grey granulation, referring tospecimens under the microscopes, showing the grey granulation in an early stage arising in the walls of a blood-vessel, and consisting of a small circumscribed nodule, not receiving injection at any part; and then the same becoming more diffuse, and in the direction in which it was extending, receiving injection, which marked out the air-cells, and gave that part so mnch the appearance of an inflammatory condition, that he had accepted it as such; and would suggest that the above observers had mistaken the past for the present tense of the grey granulation in these cases. In conclusion he described two diatheses, a scrofulous or strumous, and a phthisical. The former led to a form of inflammation of the lymphatic glands, testicles, kidneys, lungs, bones, joints, &c., which tended to rapidly undergo caseation and break-down; to such a diathesis acute miliary tuberculosis belonged, as an accident caused by the absorption of some of this caseous matter. The latter, the phthisical diathesis, was distinguished from this especially by the greater chronicity of its processes, comparing with phthisis caseous pneumonia. The deposit in the testicle which complicated phthisis, with the scrofulous testicle. Also noting the chronic way in which the peyers patches, and the larynx become affected in phthisis. He answered the question asked by the heading of his paper in this way. If the members of the society wished to consider the disseminated grey granulation resulting from the absorption of caseous matter, as tubercle; then tubercle had nothing whatever to do with phthisis. If, on the other hand, they considered the nodules occurring in the lungs in phthisis as tubercle, then tubercle had everything to do with phthisis, and he would say with Dr. Moxon, that that he did not know active phthisis without tubercle.

Mr. Cock wished to thank Mr. Paul for his excellent paper, and for the numerous specimens he had had placed under the microscopes for their inspection. He understood him to say, that tubercle was a purely accidental complication of phthisis. Mr. Cock did not agree with him; he was disposed to recognise a tubercular, and a non-tubercular form of phthisis. Catarrhal pneumonia was sometimes very similar to tubercle, and might be mistaken for it.

Mr. Day desired to remind Mr. Paul that, the idea of tubercle being due to a lymphatic irritation, was by no means a recent one, for he had read in a book about two centuries old, that phthisis was treated with 1 drachm doses of Ipecacuanha, followed by a purge to relieve lymphatic irritation of the bowels.

Mr. Giblin considered the subject too difficult for students to handle, since the greatest modern pathologists had "agreed to differ." Dr. Fox had described tubercle as an overgrowth of all the structures in lymphatic tissues, while Dr. Williams considered it as an overgrowth of the lymph corpuscles only which might become caseous and rapidly destroy the lung, or fibrous and lead to fibroid phthisis. He agreed with these latter views.

Mr. Fry adhered to Dr. Moxon's view, that all phthisis is tubercular. He spoke of Niemeyer's theories on hæmoptysis leading to phthisis, and described the transition of the grey into the yellow tubercle. He gave Dr. Moxon's characteristics of tubercle, and Dr. Owen Rees' views on tuberculosis

Mr. R. C. Richards had thought that Mr. Paul held the opinions of Addison and Niemeyer till quite the end of his paper, which he thought that Mr. Cock had misunderstood. After criticising some of the former speakers, he narrated a case of phthisis in Accident Ward. He described fibroid phthisis, and wished Mr. Paul to account for the absence of tubercle in it. He asked if phthisis were a separate diathesis from scrofula, and gave some observations of Dr. Wilks on the subject.

Mr. Taylor confessed that he did not know what tubercle really was. He gave Laennec's views, and said that Sir R. Carswell had found tubercle in a blood clot in the spleen. He gave some views of Niemeyer's, He thought that phthisis was a separate diathesis from scrofula, and made some interesting remarks about the presence of scrofula, and the absence of phthisis in Iceland.

Mr. Turner described the appearance of a miliary tubercle in the arachnoid, remarking upon the facility with which it was seen, in that position, to be a proliferation of cells, derived either from the lymphatic or fibrous sheath of the artery. He thought that the infection was always carried by the blood, and not by the lymph vessels. He agreed with Mr. Paul, that acute miliary tuberculosis was quite a

distinct disease from phthisis, and contrasted some of the chief symptoms and morbid appearances of these diseases.

Mr. A. H. Jones had read that the occurrence of a reticulun in the grey granulation depended upon the amount irritation by which it was produced; if great, only the cells were formed; but if less, probably owing to more time, the whole lymphatic structures were increased. Against Addison's views he mentioned, that tubercle generally began at the apex, while pneumonia as frequently began at the base. He did not agree with Mr. Turner that the blood-vessels carried the infection.

Mr. Utting agreed with Mr. Giblin as to the difficulty of the subject. He thought it possible, as Niemeyer had suggested, that in hæmoptysis some of the blood might get into the air-cells, and set up a process similar to tuberculosis.

Mr. Gibb did not agree with those gentlemen who objected to the subject on account of its difficulty, he considered that the great advantage of the society was to get up and learn to speak in public, and though that any one might say something on the subject. It was very clear that scrofula and phthisis were separate diatheses, for if not, phthisis would kill off all the scrofulous people, and soon none would be left. He made some remarks upon the origin of phthisis.

Mr. Shadwell wished for an explanation of senile phthisis. He thought that phthisis might be both hereditary and due to irritation.

Mr. Day made some original observations about phthisis in South Sea Islanders; and the discussion was carried on by Messrs. Utting, Taylor and Shadwell.

The chairman then called upon Mr. Paul to answer the discussion, after which Mr. Turner proposed, and Mr. F. J. Morton Palmer seconded a vote of thanks to Mr. Paul for his paper on phthisis.

The following specimens were placed under microscopes in illustration of the paper;—Croupous Pneumonia—Catarrhal Pneumonia—An accidental Tubercle in a healthy Peritoneum—Lymphatic Tissue round a Portal Vessel in a Leukæmic Liver—Lymphatic Gland in Leukæmia—Lympho-sarcoma Infiltrating Muscle—Lymphatic Structure of the Grey Granulation—Circumscribed Grey Granulation arising from a Vessel, and spreading ditto (both injected) in Miliary Tuberculosis—The Infiltration in Phthisis begining as a Peri-bronchial thichening, (injected)—The same spreading into the Air-cells, (injected).

The Sections were strained with logwood and mounted in Balsam. Two injected preparations of Lung (Acute Miliary Tuberculosis and Phthisis) were shown, from which the Sections were cut.

MEDICAL WARDS.

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The following cases were admitted from Nov. 13 to Nov. 19, 1873.

BRIGHT (PETERSHAM).

22—Broncho-pneumonia
23—Laryngitis

PHILIP.

17—Sciatica
27—Dysentery
28—Gout—Albuminuria—Bronchitis—Diluted Heart—Tricusped bruit—Enlarged Liver

STEPHEN

7—Intestinal Obstruction
18—Debility after (?) Rheumatic Fever
23—Morbus Cordis—Aortic
14—Paralysis of Forearm and Hand
33—Morbus Cordis—Mitral
42—Morbus Cordis—Mitral, and Bronchitis
44—Syphilis
45—Bronchitis

MARY.

2—Morbus Cordis—Mitral
24—Subacute Rheumatism

ADDISON.

8—Rheumatism
13—Morbus Cordis, Mitral
26—Morbus Cordis—Mitral, and Bronchitis
30—Chorea
38—Phthisis

MIRIAM (Clinical).

25—Abdominal Tumour
31—Laryngitis
32—Paralysis

JOHN (Clinical).

1—Sequelæ of Fever?

SURGICAL WARDS.

—o—

The following cases were admitted from Nov 13 to Nov. 19, 1873.

ACCIDENT.

11—Fractured Ribs
12—Fractured Fibula
13—Contusion of Leg
15—Crushed Fingers
16—Fractured Thigh
16—Concussion
22—Fractured Tibia and Fibula
23—Fractured Patella

CORNELIUS.

1—Scalp Wound
5—Severe Injury to Abdomen
15—Fractured neck of Femur
20—Crushed Fingers

LYDIA

1—Abscess of Leg
2—Enlargement of Lower End of Femur
3—Abscess of Leg
6—Inflamed Heel
23—Ulcer of Leg
26—Lacerated Wound of Thigh

MARTHA

5—Adenocele of Mamma
17—Abscess of Leg
21—Spinal?

LAZARUS.

14—Burn of Hand

LUKE.

7—Hæmorrhoids
19—Necrosis of Leg

NAAMAN.

6—Abscess of Popliteal Space
9—Strangulated Inguinal Hernia
10—Abscess over Patella
13—Hydrocele
15—Malignant Tumour of Lower Jaw
22—Necrosis of Ankle-joint

JOB.

6—Perinæal Section
8—Retention of Urine (Puncture per Rectum
22—Hydrocele

CHARITY.

7—Ulcers of Foot
22—Talipes Varus

DORCAS

1—Diffused Inflammation of Bursa Patellæ
7—Ulcer of Thigh
11—Malignant Disease of Knee
18—Talipes Equino-varus
9—Carcinoma of Mamma

UNIVERSITY OF LONDON.

Second M.B. Pass Examination, 1873.

Monday, November 3—Morning, 10 to 1.

Obstetric Medicine.

Examiners—Robert Barnes, Esq, M.D., and Prof. Graily Hewitt, M.D,

1. What are the signs of Rupture of the Gravid Uterus? At what periods of pregnancy does this accident occur?

2. What are the varieties of Transverse Presentation of the Fœtus? Describe the treatment.

3. The fœtal head being retained *in utero* after separation of the body:—(1) What are the probable issues, if it be left there? (2) How would you proceed to extract it?

4. Define "Accidental Hæmorrhage;" and describe the symptoms, causes, and treatment.

5. Describe the objective signs of Pregnancy at the end of three months; and show how pregnancy at this period is distinguished from other conditions which may simulate it.

6. What are the causes of Dysmenorrhœa?

Monday, November 3—Afternoon, 3 to 6.

General Pathology, General Therapeutics, and Hygiene.

Examiners:

J. Syer Bristowe, Esq., M.D., and Prof. Wilson Fox, M.D., F.R.S.

1. What do you mean by Expectorants? How do you suppose that they act; and with what special object would you administer them?

2. Describe the different modes in which Cysts become developed.

3. Give the symptoms and pathology of Trichinosis, including a description of the animal, and its life-history.

4. Enumerate the remedies, other than mechanical, which may be useful in arresting Hæmorrhage? and state the probable mode of action of each.

5. Describe the local phenomena of the circulation in Inflammation.

6. Describe the clinical differences between Small-pox, as occurring in a person previously vaccinated, and in one not so protected. What is the relative prognosis of the disease under these different circumstances?

Tuesday, November 4—Afternoon, 3 to 6.

Medicine.

Examiners—J. S. Bristowe, Esq., M.D., and Prof. Wilson Fox, M.D., F.R.S.

1. Give an account of Pemphigus and discuss its relations with constitutional diseases and other forms of skin affection.

2. What are the causes of Dropsy, and how may they be best counteracted?

3. What are the causes and symptoms of Cerebral Hæmorrhage?

4. Describe Collapse of the Lung: explain its causes and its possible consequences; and state its appropriate treatment.

5. Enumerate in detail the causes of Diarrhœa in Infants, prior to dentition; and describe fully its appropriate treatment.

6. Describe the secondary effects on the Heart, and on other organs of (a) Incompetence of the Aortic Valve; (b) Incompetency of the Mitral Valve; (c) Constriction of the Mitral Orifice; and illustrate the mode in which such effects are produced.

Wednesday, November 5—Morning, 10 to 1.

Forensic Medicine.

Examiners—Arthur Gamgee, Esq., M.D., F.R.S., and Prof. Maudsley M.D.

1. When several persons perish by a common Accident, what circumstances should be taken into consideration in forming an opinion as to probability of relative survivorship?

2. Mention the signs upon which you would chiefly rely in determining the maturity of a Child at birth.

3. Importance is sometimes attached, in the identification of living persons to the persistence or disappearance of Scars and Tattoo-marks. State all that you know on these points, which would guide you in forming an opinion in a case of doubtful identity in which tatto-marks or scars were alleged to have existed, and to have disappeared.

4. Describe the means which you would adopt to determine whether stains on linen, cloth, &c., were or were not blood stains.

5. Describe the symptoms of Poisoning by Strychnia, distinguishing them from similar symptoms produced by disease. What treatment would you adopt in such a case? and how would you proceed to detect the poison after death?

6. What steps are legally necessary before removing an Insane person from his own home and placing him under restraint?

AUTOTYPE OF MR. COPE'S PICTURE OF THOMAS GUY.—This handsome picture is still on sale at the Counting House, any profit arising therefrom being placed to the credit of the "Guy's Samaritan Fund." Guy's men will do well to procure this interesting memento of their Alma Mater It can be sent into the country securely packed in boards. Mr. Williams, at the Counting House, will be happy to show the picture and give all information.

FOOTBALL CLUB.

II. GUY'S v. ST. THOMAS'S.

This match was played at Blackheath on Saturday, November 15th, and resulted in an easy victory for Guy's, by three goals, three tries, and several touch downs to nothing. The touch downs were obtained by Mutch, Carey and Smart, and the goals were kicked by Poland and Jackson. The following Fifteen played:—Captain—A. Carey; backs—Jackson and Poland; half-backs—Smart and Garder; forwards—Mutch, Porter, E. Duke, Dring, Maltby, W. C. James, Mainwaring, Roberts, Peskell and Reader. The St. Thomas's men played two short.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

This match was played on the University ground at Victoria Park, on Saturday, November 8th, and resulted in a draw, in favour of us, by one goal (a fine drop of Robson's,) a try (Maclean,) and one touch down, to a goal (drop by Alfred) and three touch downs. The following played for Guy's:—Captain—Robson; back—Breach; half backs—Finch and Maclean; three-quarter back—Gibb; Rendall, Gilbert, Wells, Gray, Collins, H. Duke, Hetley, Wallis, Brown and Simmonds.

GUY'S v. ST. MARY'S.

This match was played on the ground of latter, at Primrose Hill, on Saturday, November 15th, and resulted in favour of Guy's, by three tries and seven touch downs to nothing. It was very unfortunate that we were unable to kick a goal, but no doubt the eccentric and wretched condition of the ground, had a good deal to do with this, Maclean obtained two, and Welchman the remaining try. The team playing was:—Captain—Robson; back—Breach; half backs—Maclean and Welchman; three-quarter back—Gibb; Rendall, Gilbert, Wells, Hetley, Wallis, H. Duke, Brown, Collins, Elliot and Johnson.

MATCHES THIS DAY.

First Fifteen *v.* London Hospital, at Blackheath. Second Fifteen *v.* St. Paul's School, at Battersea Park.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

FOR SALE.

If Gentlemen, who are at PRESENT GUY'S STUDENTS have any Article of a Professional character to dispose of, they may advertise the same in this Column at the price of One Shilling for Advertisements not exceeding Twenty Words.

BONES—A Student has a number of BONES, which he is willing to dispose of cheaply. Applications for the same te be made to "Richmond," at the Publishing Office, 104, Borough, S.E.

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A RED CROSS on the wrapper means that the subscription is due.

Gentlemen who have sent us Subscriptions from the country will kindly consider the receipt of the "Gazette" to be sufficient acknowledgment for the same.

A number of Subscriptions for back copies of the GAZETTE are still owing. Gentlemen will oblige by paying the same at once to FRANK T. PAUL, E. O. GIBLIN, or the Publisher, ORLANDO G. BRIMMER, 104, Borough High Street, S.E., hom to wPost Office Orders should be made payable at the Borough Post Office; or by HALFPENNY Postage Stamps.

EDITORIAL NOTICES.

All communications to he addressed to
The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.
And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed:

We reserve the right of omitting any communications that may be received by us.

A limited number of Advertisements by persons who are not Students may be inserted at the following rates:—

Seven lines and under - - -	0	2	6
One-eighth of a Page - - -	0	5	0
Quarter of a Page - - -	0	9	0
Half of a Page - - -	0	17	0

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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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SURGICAL INSTRUMENT MAKER,

46, KING STREET, BOROUGH, S.E.

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OPTICIAN,

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Mr. Le Gros Clark's Hernia Knife.
Mr. Bryant's Nasal Polypus Snare.
Mr. Wagstaffe's Bulbous Catheters.
Mr. Moon's Fractured Jaw Apparatus.
Mr. Sidney Jones' Ovariotomy Forceps.

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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER at 104 Borough High-street, Southwark, Surrey.—Saturday Nov. 22, 1873

Guy's Hospital Gazette.

VOL. III.—No. 9. SATURDAY, NOVEMBER 29, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

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THE BLOOD,

BY HENRY ASHBY.

Hæmoglobin or hæmatocrystalline is the best known constituent of the red corpuscle. It is a red crystalline substance having the remarkable looking formula of $C_{600}H_{960}R_{154}Fe\,S_3O_{177}$, and therefore an atomic weight of 13,280. Though crystallizable it is indiffusible, or only slightly diffusible through animal membranes, this is perhaps due to the enormous weight of its molecule.

Its solubility and also its crystalline form depends to some extent on the animal, from which it is derived. That of the horse is very soluble, and not easily obtained in crystals, while that of the guinea-pig crystallizes readily at ordinary temperatures.

By adding a drop of water to a drop of guinea-pig's blood and allowing it to evaporate, crystals will form.

The hæmoglobin of the dog is soluable at the temperature of the body, but sparingly so at 0°C. or in 20 p.c. alcohol at a higher temperature.

The first step in its preparation, must be to make it quit the corpuscles; water, ether, chloroform and cholic acid may be used for this purpose, they have the power of rendering the blood transparent or "laky," by dissolving out the hæmoglobin from the corpuscles.

Hæmoglobin crystals may be prepared in small quantity, by adding a few drops of water to a drachm of defibrinated dogs blood, adding $\frac{1}{4}$ of its bulk of ordinary alcohol, and immersing it in a mixture of ice and salt. Crystallization ensues from the combined action of cold and addition of alcohol.

Another way suggested by Kuhne answers well. Defibrinated dog's blood is thoroughly shaken with ether, and exposed to cold by standing in ice for twenty-four hours, when it is converted into a solid mass of crystals.

These may be washed with 20 p.c. alcohol, dissolved in a minimum of water, and recrystallized by the addition of water and exposure to cold.

On boiling a solution of hæmoglobin, it splits up into an albuminous body, and a brown colouring matter—hæmatin—which contains the iron of the original salt. When hæmoglobin is in contact with air, it is in combination with oxygen. It is however very loosely combined with its oxygen, and parts with it very easily in presence of reducing agents, and when subjected to diminished atmospheric presure. ($\frac{1}{6}$th of an atmosphere.)

Carbonic acid while affecting the colour of the hæmoglobin does not combine with it, the corpuscles are not the carriers of CO_2.

It is different with carbonic oxide Blood saturated with CO is entirely deprived of O, and replaced by an equivalent of CO. The CO cannot be dislodged by any reducing agent. Hence one of the most important functions of the blood is destroyed if it absorb CO, as when asphyxia occurs from the inhalation of charcoal fumes.

Both hæmoglobin and hæmatine possess the remarkable power of blueing guaiacum resin in presence of peroxide of hydrogen. Fibrin gives the same reaction only in slight degree, but the difficulty of completely freeing fibrin from the red colouring matter renders the result somewhat uncertain.

Fibrin steeped in water, which was repeatedly changed for a week and rendered colourless, after soaking in ethereal solution of H_2O_2 became greenish-blue on being placed in Tr. Guaiaci. Guaiacum und rgoes a slight change of colour from brown to green when exposed to the action of air, a change probably due to oxidation. It is more readily changed by the action of certain substances, as mucus, saliva, milk. And it rapidly becomes intensely blue on the addition of certain reagents as potassic permanganate and chromic acid.

All the substances which affect the colour of the guaiacum alone do so more readily in presence of H_2O_2

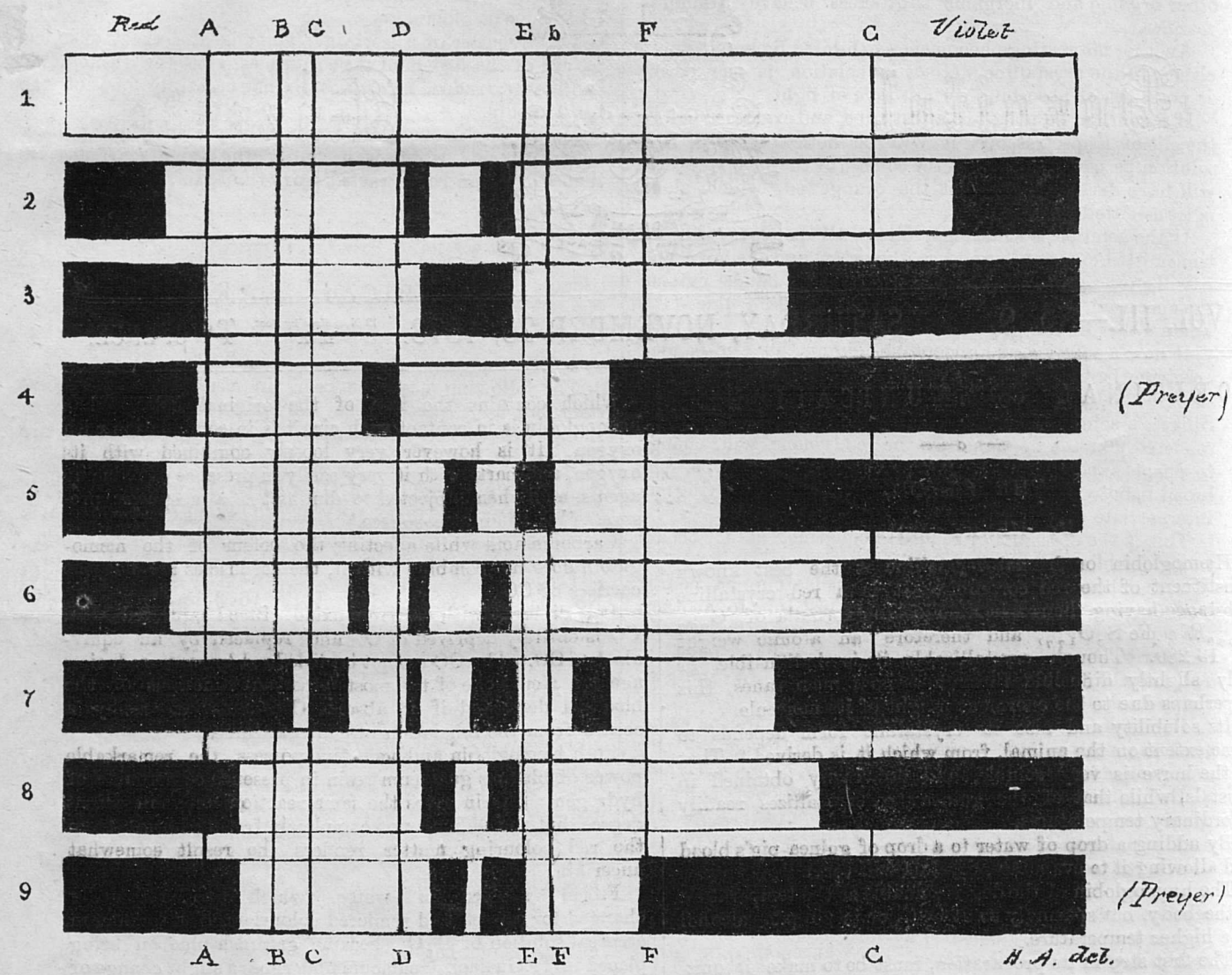
Hæmoglobin according to the majority observers (including A. S. Taylor) is unique in its reaction, in not affecting the colour of the resin until H_2O_2 is added.

Burdon Sanderson, however states that a deep blue ring is formed, if a solution of hæmoglobin be added to Tr. Guaiaci on blotting paper.

In my own experiments, I found that if the guaiacum were prepared as Dr. Taylor directs from the pure resin unaltered by exposure, no effect was produced upon it by the hæmoglobin.

But if on drying, the guaiacum presented a greenish colour, the hæmoglobin produced a greenish blue ring

Absorption Bands of Blood.



2 Oxy hæmoglobin 5 Red. Hæmatin 8 Hæmoglobin + CO

3 Red. hæmoglobin 6 Hæmoglobin & Hæmatin 9 Hæmoglobin + ACH

4 Oxy. hæmatin 7 Hæmobom 1 Solar

round its edge, but nothing that could be called a deep blue ring.

It is obvious that such a point should be definitely settled, for if as asserted hæmoglobin oxidises the resin before the addition of H_2O_2, its value as a test for blood in medicolegal inquiries becomes seriously impaired, as many other organic and inorganic substances behave in similar manner.

Another interesting phenomenon exhibited by hæmoglobin either, in the crystalline state or in solution, is the power it possesses of absorbing certain rays of light.

If a solution be placed in a test tube, and examined before the slit of a spectroscope, it will be noticed that if the solution be concentrated, all the colours of the solar spectrum will have disappeared except the orange-red, which alone is transmitted.

If the solution is sufficiently dilute, all the rays will be transmitted except a number in the green and yellow, and it will present the appearance of two dark bands cutting the spectrum, one in the yellow near the sodium line (D), and another in the green (2), *see diagram.*

If now a solution of hæmoglobin giving the two-banded spectrum be treated with a reducing agent as ammonium sulphide and gently warming, or the original reagent used by Stokes, a solution of ferrous sulphate and tartaric acid rendered alkaline by ammonia, the red colour will change to purple, and on examination with the spectroscope, one broad band will be seen in place of two and occupying an intermediate position (3).

This is the spectrum of reduced hæmatine, as it occurs in venous blood.

If the above solution of reduced hæmatine be poured once or twice though the air from one test tube to another, the same result occurs as when blood passes through the capillaries of the lungs, the purple colour gives place to red, and the single broad band is replaced by the two banded spectrum of arterial blood.

Hæmoglobin is slowly decomposed by exposure for some time to the air or by the addition of various reagents, new colouring matters being formed as *hæmatine, hæmin, hæmatoin.*

Hæmatine is gradually formed when solutions of hæmoglobin are rendered alkaline by the addition of the caustic alkalis or an acid.

The red colour changes to brown and a dark band in the orange appears when its solution is viewed by the spectroscope.

It is generally accompanied by the band in the green and yellow of either oxygen or reduced hæmoglobin, as it is obtained with difficulty in the pure state. (4.)

If a solution which has undergone this change is subjected to the action of reducing agents as ammonium sulphide or ferrous sulphate, the brown colour changes to a pinker hue, the band in the orange disappears and two new dark bands, in the green appear nearer the violet end of the spectrum than the bands of hæmoglobin, reduced hæmatine being formed, (5.) On shaking with air, the orange band of hæmatine reappears.

When blood becomes extravasated in the body as in clots from old cerebral hæmorrhage or in paroxysmal hæmatinuria, hæmatine is formed, fig. 6 was drawn from the spectrum of urine in a case of hæmatinuria.

Hæmin closely resembles hæmatine, but differs from it by containing an additional equivalent of HCl.

Hæmin crystals may be obtained by treatiug dried mammalian blood with a few crystals of common salt, and a drop of acetic acid on gently warming brown crystals of hæmin are formed.

When acetic acid is added to hæmoglobin decomposition takes place, the iron combining with the acetic acid and a new substance of a reddish brown colour free from iron, called *Hæmatoin* is formed.

If the above solution be shaken with ether and examined by the spectroscope, four bands will be seen. (7.)

Several other substances exists in the red corpuscles besides hæ moglobin.

It is a matter of uncertainty what is the exact chemical nature of the stroma of the corpuscles, after the hæmoglobin has been extruded. *Paraglobulin* is certainly one of the constituents.

Hoppe Seyler has demonstrated the presence of *lecithine* or *cerebric acid,* which is probably the same substance as that which can be extracted from the brain.

MEDICAL WARDS.

—o—

The following case has been in the Hospital for some time, but as it presents several points of interest, it was thought that a very condensed report—for which we are indebted to Mr. Thomas S. Morley—would be useful :—

CASE OF ULCERATIVE ENDOCARDITIS, WITH EMBOLISM AND CONSEQUENT HEMIPLEGIA—PECULIAR SYMPTOMS DURING THE RECOVERY OF MOTOR POWER.

Frederick Cutler, æt. 22, a hawker, was admitted into No. 7, Philip Ward on March 12, 1873, under the care of Dr. Moxon.

Family history good. Two attacks of rheumatic fever—one two years' ago, the other one year since. No ill consesequences felt until present illness. A month ago got his feet wet in the snow and caught cold. Had no medical assistance, but went about until four days ago, when the pain in his chest and the cough were so bad that he could not go out. Two days ago he came to Dr. Taylor's outpatients, and was advised to come into the Hospital.

On Admission—the principal abnormalities found were slight general œdema, rales at back of chest on both sides, heart irregular, impulse strong, apex beat in 6th intercostal space 1in. external to nipple. Systolic bruit at apex, heard indistinctly behind. First sound at base not quite clear. Ordered Tinc. Digitalis 10 m. c. Mist. Senegæ. Gradually improved by treatment. On the evening of the 26th had a febrile attack with pain, but no swelling, in the elbows, wrists, and shoulders. Pain in the left side, but no evidence of lung mischief. Breath short.

March 28—Temp. 99, pulse 64, resp. 30.

March 29—Temg. 98·4, pulse 50, resp. 30.

May 1—Pain in chest gone. There is a systolic bruit at the base in addition to the former one at the apex. No pain in joints now.

After this he improved under the action of Tinc. Digitalis 10 min., and went out May 23.

July 24—Was re-admitted, with an aggravated degree of his previous condition. There was then a syatolic bruit at the apex, and a to and fro bruit at the base.

After admission, he was principally relieved by 15 min. doses of Tr. Digitalis. He was able to get about the ward, suffering from occasional attacks of severe pain in the precordial region, with breathlessness lasting two or three days.

Sept. 20—Noticed that he was asleep during the greater

part of yesterday, and did not disturb him. Is now very drowsy. Occasional deep drawn sighs, but no evidence of dyspnœa. Face flushed. Pulse 53 irregular, temp. 97·3. Face drawn to right. Protrudes his tongue to left, and when asked to show his teeth moves only the right side of mouth. Cannot move left arm or leg. Pain in right temple complained of. Ordered, Pil. Cal. cum Col. 5 gr., statim.

Sept. 22—Nurse says that the attack commenced with what she thought to be a fainting fit while he was in bed, after which he became very drowsy. Opens both eyes, and moves both eyeballs consensually. Loss of sensation over whole of left side and face.

Sept. 23—Complains of pain in right side. Resp. 12, pulse 46. No evidence of lung trouble.

From this time he gradually got less drowsy, lost the pain in his head, and regained his appetite. His pulse gradually rose to about 70, but still irregular.

Oct. 6—He could move his left leg a little. The return of sensation and motion advanced equally. Moderately good sensation to contact was present on Oct 10, while there was entire absence of sensation to heat at this time.

Oct. 22—Trouble with breathing. Lungs appear healthy. Liver 2in. below ribs. Slightly dry cough. Appetite good. Temp. 99·4, pulse 130, resp. 24.

Oct. 28—Temp. 98·7.

Oct. 30—Pain, which came rather suddenly just below popliteal space. Tenderness on pressure. Popliteal and both tibial arteries felt beating. Temp. 97·7. Good reaction on left side to Faradic current. Sensation to current similar in extent to that of common sensation. Face re-acts well to Faradic current, but there is no sensation to current on left side.

Faradization applied to left arm since Oct. 22.

Nov. 8—Finds that while clasping his right hand very tightly he is able to flex his left elbow to a considerable extent by voluntary effort. Is unable to move the left fingers or shoulder while so doing. Is also unable to flex the left elbow when the muscles of the right hand are not in action.

Nov. 15—Can nearly close his left fingers by a strained and voluntary effort. When he succeeds in moving them the motion is always accompanied by an involuntary contraction of some of the muscles of the right arm and also of the flexors of the left elbow. Voluntary flexion of the right fingers does not increase that of the left ones. Cannot shrug both shoulders at once.

N.B.—Much of the treatment has been necessarily omitted in this report, as having no very important bearing on the more interesting points of the case.

The following cases were admitted from Nov. 20 to Nov. 26, 1873.

BRIGHT (PETERSHAM).

1—Tonsilitis
9—Phthisis

PHILIP.

20—Regurgitant Mitral—Adherent Pericardium
26—Dyspepsia
37—Bronchitis—Pleurisy, right base
44—Enlarged Glands in Neck—Slight Bronchitis
48—Acute Rheumatism
50—Chronic Bronchitis—Emphysema

MARY.

7—Bronchitis and Emphysema
1—Phthisis
9—Syphilis

STEPHEN

11—Chorea
15—Ataxia
19—Albuminuria, &c.
25—Rheumatism
26—Phthisis
28—Rheumatic Fever—Pericarditis
32—Impetigo
37—Bronchitis and Emphysema
38—Chronic Rheumatism
40—Diabetes—Phthisis
50—Chronic Rheumatism

ADDISON.

4—Bronchitis
8—Rheumatism
10—Pregnancy
13—Hemiplegia
14—Chorea, with Partial Paralysis
21—Cystitis
22—Abdominal Tumour—Hydatid (?)
30—Chorea

MIRIAM (Clinical).

22—Acute Nephritis
23—Enlarged Liver
24—Febricula
27—Laryngitis
29—Coma following Convulsions

JOHN (Clinical).

7—Syphiloma of Liver
9—Old Pleurisy
12—Intermittent Hæmaturia

SURGICAL WARDS.

—o—

The following cases were admitted from Nov 20 to Nov. 26, 1873.

ACCIDENT.

21—Contusion
23—Fractured Internal Condyle of Femur
29—Fractured Tibia and Fibula
32—Severe Injury to Spine

LUKE

6—Tumour of Neck
12—Calculus Vesicæ
18—Psoas Abscess

NAAMAN.

1—Disease of Elbow-joint
3—Abscess of Axilla
4—Scalp wound
9—Strangulated Inguinal Hernia (operation)
11—Senile Gangrene
14—Necrosis of Tibia
17—Epithelioma of lower Maxilla

MARTHA

7—Carcinoma Mamæ
17—Fistula in Ano

JOB.

23—Injury to Face from Dynamite explosion

DORCAS

8—Fractured Fibula
9—Partial Anchylosis of Knee
10—Nasal Polypus
13—Necrosis of Tibia
16—Fractured Tibia
24—Severe Scald (death)

CORNELIUS.

1—Scalp Wound
3—Lacerated Wound of Hand
5—Fractured Cervical Vertebræ
9—Fractured Fibula
15—Fractured Neck of Femur (Intracapsular)
16—Ruptured Bladder

LYDIA

8—Nævus of Neck
20—Disease of Knee-joint

LAZARUS.

5—Traumatic Stricture
6—Fistula in Ano
8—Hæmatocele

CHARITY.

5—Talipes Varus (both feet)
11—Hip Disease
24—Flat Foot

APPOINTMENTS.

The following fresh appointments were made at a meeting of the Medical Council, held Tuesday, Nov. 25, 1873:—

OBSTETRIC ASSISTANTS.—Messrs. Ashby, Paul, and Willtams.

DRESSERS.—Messrs. Morley and Day to Mr. Birkett; Mr. Harsant to Mr. Cooper Forster; Mr. Lees to Mr. Bryant; Messrs. Nunez and Fry to Mr. Durham.

DRESSERS IN THE EYE WARDS.—Messrs. Sepmour, French, Evans, and Norton Taylor.

CLINICAL ASSISTANTS.—Messrs. Sangster, W. E. Paley, E. Field, Gibb, E. Hicks, and H. N. Smith.

MEDICAL CLINICAL CLERKS.—Messrs. Walker, Crouch, Dring, Treharne Lamb, Ockendon, W. Brown, Newman, J. S. Johnston, W. Ferrier, Rees, Hobson, G. H. W. Thomas, W. M. Jones, R. C. Richards, J. H. Vinter.

DENTAL SURGEONS' DRESSERS.—Messrs. Boyd, Tyson, Cock, Forty.

ASSISTANT SURGEONS' DRESSERS.—Messrs. Coates, Alexander, Boddy, Bowen, Lovett, W. M. Jones, MacCullagh, A. Jones, H. Duke, Barlow, E. Newton, A. L. Bowen, W. Snook, Gwatkin, Caddy, and Lancaster.

ASSISTANT PHYSICIAN'S CLERKS.—Messrs. Winkworth, Giblin, Clyde, Adkins, Cock, Dennis and Mitchell (skin).

DRESSERS IN SURGERY.—Messrs. Adcock, Breach, J. Brown, Welchman, Utting, T. Smith, Routh, Hayes, Finch, Bunchley, C. G. Lee, Coley, Bull, Theed, Bartlet, Kellard.

P.M. CLERKS.—Messrs. A. W. Green, Jackson, H. C. Taylor, C. N. Johnson. G. Davis, H. C. Burton.

OBSTETRIC OUT-PATIENT CLERKS.—Messrs, E. O. Reynolds, H. Clarke, J. W. Romano, Crowther.

ASSISTANT SURGEONS' CLERKS.—Messrs B. Giles and R. Cusack.

STATISTICAL ACCOUNT OF GUY'S HOSPITAL SURGERY

FOR OCTOBER, 1873.

MALE SURGERY. Cases treated 770.		FEMALE SURGERY. Cases treated 300.	
Diarrhœa	27	Teeth Extracted	114
Teeth Extracted	132	Burns and Scalds	10
Burns and Scalds	13	Sprains and Contusions	60
Sprains and Contusions	146	Diarrhœa	15
Incised wounds	73	Scalp Wounds	6
Retention of Urine	16	Bites from Dog	3
Scalp Wounds	42	Dislocations—	
Crushed Fingers	6	Humerus (1) Subcoracoid	1
Dislocotions—		(2) Subclavicular	1
Humerus (Subcoracoid)	2	Separation of Epiphysis at Head and Femer	1
Phalanx	3	at Elbow	1
Ulna and Radius (backwards)	2	Fractures—	
Clavicle (forwards)	1	Ribs	4
Fractures—		Clavicle	7
Ribs	7	Ulna	4
Radius	4	Humerus	1
Ulna	3	Metacarpal Bones	1
Ulna and Radius	3	Phalanx of Hand	1
Humerus	3		
Clavicle	5		
Metacarpal Bones	2		
Phalanges	9		
Nasal Bones	2		

J. LACEY MORLEY,
Junior House Surgeon.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

SESSIONAL EXAMINATIONS.

With the view of still further developing the system of Sessional Examinations heretofore in force in this College, the Council have adopted the following ordinances:—

That all such students as have commenced their professional studies on or after the First day of October, 1871, shall, except in such case as has been otherwise provided by the Bye-Laws, be required, in order to entitle them to the Letters Testimonial of this College, to produce satisfactory evidence of having passed the Sessional Examinations hereinafter provided.

Students who have commenced their professional studies previous to the 1st of October, 1871, will also be permitted, should they so wish it, to avail themselves of these Sessional Examinations for the purpose of obtaining their Letters Testimonial.

These Sessional Examinations shall be three in number, and shall be held in the following order, three times in each year, on the second Tuesday in April and July, and the first Tuesday in December, subject to such alterations in date as the Council shall direct. The Student may present himself for

(*a.*) The First Examination at the termination of the Second Winter of medical study.
(*b.*) The Second Examination at the termination of the Third Winter Session of medical study.
(*c.*) The Pass Examination at the termination of the Third Summer Session of medical study.

No student shall be permitted to proceed to either the Second or Pass Examinations without having produced evidence of having passed the preceding examination.

THE FIRST EXAMINATION.

For this examination the candidate shall be required to produce the following certificates :—

(*a*) Preliminary Examination; (*b*) Practical Anatomy, with demonstrations and dissections, two winter sessions; (*c*) Physiology, two courses; (*d*) Surgery, two courses; (*e*) Theoretical Chemistry, one course; (*f*) Practical Chemistry, one course; (*g*) Materia Medica, one course; (*h*) Botany, one course; (*i*) Hospital Attendance, fifteen months.

Subjects for Examination.

a. Anatomy (bones, muscles, articulations, and the topographical anatomy of the viscera of the chest and abdomen.
b. Physiology—of bone, muscle, and the fibrous tissues.
c. Surgery—Fractures and Dislocations.
d. Inorganic Chemistry*.
e. Materia Medica of the British Pharamacopœia (not including Therapeutics).

Fees for this examination, £5 5s. for Registration, † and £5 5s. for Examination.

The subjects and curricula of the Second and pass Examinations are under the consideration of the Council.

Mode of Conducting of the Examination.

Each examination shall occupy two days, the first of which two days shall be devoted to the writing of answers to written or printed questions; and the second to *viva voce* examination.

For the written examination four hours shall be allowed —two in the forenoon and two in the afternoon; but any candidate may retire from the hall on completing his papers, and handing them to the examiner.

The *viva voce* examination shall commence on the day following the written examination, and shall be continued as may be necessary from day to day—each candidate being submitted, as heretofore, to one hour's examination at least.

GENERAL RULES.

At the conclusion of each examination, the candidate shall be informed of the result by letter, forwarded to his address by post or otherwise.

Any candidate for the Letters Testimonial to whom the Council may grant a special examination, shall be required to pay, in addition to the foregoing fees, a sum of Five Guineas.

Each candidate rejected at any examination shall pay for re-examination a fee of Two Guineas, additional to that which he has already paid.

ROYAL COLLEGE OF SURGEONS.

The following gentlemen were admitted Members :—

On Wednesday, Nov. 19—Messrs. O'Brien, Chadwick, Clunn, Hawton, Lloyd, and Rigby.

On Thursday, Ndv. 20—Messrs. Day, Keyworth, and Whittington.

On Friday, Nov. 21—Messrs. Davenport, Evans, and Simmonhs.

STUDENTS' BIBLE CLASS.—The next meeting will be held on Tuesday next, Dec. 2, at 6.30, at Hibernia Chambers, London Bridge. Subject—John vi. 26-46.

ERRATA.—In our last issue, on page 58, line 21 from bottom for "high enormous pressure," read "high enough pressure."

CORRESPONDENCE.

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents*]

To the Editor.

Sir,—I am an old student of Guy's Hospital, and now hold an appointment it its neighbourhood. On Thursday night last, an urgent surgical case occurred in my practice, and I found myself in sore need of some Guy's adhesive plaister. I went immediately to the Hospital to procure it, and as I reached the Surgery, a dresser came out of the rooms on his way to one of the Wards. With a word of apology for troubling him, I asked him to give me some strapping, stating at the same time the emergency of the case for which I required it. He stared at me, and said "who are you?" I modestly explained that I was a former student, and told him what appointment I am *now* holding. He said it was not usual to give away plaister and abruptly left me. I was glad when he did for his manner was offensive, and yet at this time, I felt I was suffering a sort of delayed retribution, and also understood the feeling which actuated him, for I remember after I had entered about six weeks, I was made a night casual, and I used to feel I was rather letting myself down in speaking to a fellow who was not a night casual; but, I hope that in succeeding appointments a better and more Guyite feeling prompted me. I got a roll of plaister from the nurse and retired in some disgust. The only comment I offer, is that I thank God there were no students like him in my day, and I ask present Guy's men if they approve of the conduct of one of their number to a former student in the hour of his need. I enclose my card, and remain

Your obedient Servant,

A.

November 19th, 1873.

NEURALGIA.

(A Summary from Tomes' "Dental Surgery.")

Pain resulting from a diseased condition of a part, is by no means invariably referred to the spot whence it really originates, but is felt in some distinct, and often remote place.

A familiar example of this is afforded by the pain resulting from hip-joint disease, which is referred to the knee. Dr. Cayley ("Archives of Dentistry," vol. 1.) says "that the attack, when it is dependent on diseased teeth, almost always comes on in the evening," and in referring to the influence of the teeth, Dr. Anstie writes, "It is an undoubted fact that they may cause neuralgia of a very serious type, and attended with excessive complications."

There is no more fertile source of error than to suppose that amelioration, or even temporary cure, indicates that the cause is not a tooth. As there is no character by which neuralgia dependent on the teeth can be distinguished from the other forms of the disease, it becomes necessary to examine somewhat minutely the various morbid conditions of the teeth which are capable of setting it up. The occurrence of neuralgic pains during the eruption of the wisdom teeth may in some instances be due to the gradual elongation of the fangs of the wisdom tooth pressing upon and diverting from their course the nerve trunks. There are many cases of neuralgia really dependent on diseased teeth, of which it is almost impossible to be certain before their removal; for instance, there may be many stumps in the mouth, any one, or all of which are capable of setting up neuralgia. It may be mentioned that the paroxysms have a tendency to periodicity, often recurring with great regularity; the coming attack may often, and indeed generally, be warded off by a full dose of quinine, but when quinine is given with this object, it must be given in large doses—from 5grs. to 10grs. for an adult; small doses, frequently repeated, are often perfectly ineffective in a patient who is at once relieved by a full dose. The large dose is better tolerated if a saline purgative be given some two or three hours before taking the quinine, which should itself be administered about an hour and a half before the time at which the recurrence of the pain is expected.

FOOTBALL CLUB.

—o—

GUY'S v. LONDON HOSPITAL.

This match was played last Saturday, November 22nd, on our ground at Blackheath, and resulted in a victory for us, by a goal, a try and six touch downs to nothing. London won the toss, and elected to play with a strong wind and slight hill in their favour, but still Guy's kept the ball well in the centre of the ground, if not in the London territory, the play of our men behind the scrimmages, being particularly good. At half-time, goals being changed, the superior weight of Guy's began to tell, and after some good play all round, a try was obtained. Simmonds being the last to handle the ball, the place-kick by Gibb, a difficult one failed, the ball going rather to one side, after this, till the end of the game, we penned our opponents, compelling them to touch down several times in self-defence and just before time, Mutch ran in, and touched the ball down between the posts, this Gibb converted into a goal. It will be seen by the following, that several prominent men of our team, were not playing, but their places were admirably filled, as the result of the match shows. The following was the team :—Backs —Robson (Captain) and Breach; three-quarter back—Day; half backs—Finch and Brown; Gibb, Gilbert, H. Duke, Mutch, Hetley, Wallis, Collins, Wilkinson, Elliot and Simmonds.

GUY'S (II. Fifteen) v. ST. PAUL'S SCHOOL.

The above was played at Battersea Park, on Saturday, November 22nd, and after a good match, ended in favour of Guy's by two tries, three touch downs, and a fine "run in" by Gardner just before time was called, to one try. For Guy's, Johnson, Gardner, Smart and James played well, while L. S. White, Savory and E. G. Windle distinguished themselves for St. Paul's. The following Fifteen played :—Guy's—Captain—A. Carey; backs—Jackson and Poland; half backs—Smart and Johnson; E. Duke, Maltby, James, Porter, Gardner, Perry, Mainwaring, Roberts, Peskell and Champneys. St. Paul's :—Quarter backs—Wallis (Captain) and Savory; half backs—Jackson and R. H. White; backs—McMurtric and Tuke; Damant, Lipscomb, Metcalfe, Montague, Templer, L. S. White, W. E. Windle, E. G. Windle and Yates.

MATCHES THIS DAY.

First Fifteen *v.* Clapham Rovers, at Balham. Second Fifteen *v.* Grasshoppers, at Blackheath.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country,—The Progress of Medicine, by Dr. Prowce James.

ANSWERS TO CORRESPONDENTS.

Mr. Edmund Aikin is much thanked for his valuable communication which shall appear in our next issue.

BONES—A Student has a number of BONES, which he is willing to dispose of cheaply. Applications for the same te be made to "Richmond," at the Publishing Office, 104, Borough, S.E.

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Gentlemen who have sent us Subscriptions from the country will kindly consider the receipt of the "Gazette" to be sufficient acknowledgment for the same.

A number of Subscriptions for back copies of the GAZETTE are still owing. Gentlemen will oblige by paying the same at once to FRANK T. PAUL, E. O. GIBLIN, or the Publisher, ORLANDO G. BRIMMER, 104, Borough High Street, S E., hom to wPost Office Orders should be made payable at the Borough Post Office; or by HALFPENNY Postage Stamps.

EDITORIAL NOTICES.

All communications to be addressed to
The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.
And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

A limited number of Advertisements by persons who are not Students may be inserted at the following rates :—

Seven lines and under - - -	0	2	6
One-eighth of a Page - - -	0	5	0
Quarter of a Page - - -	0	9	0
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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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Mr. Le Gros Clark's Hernia Knife.
Mr. Bryant's Nasal Polypus Snare.
Mr. Wagstaffe's Bulbous Catheters.
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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER at 104 Borough High-street, Southwark, Surrey.—Saturday Nov. 29, 1873

Guy's Hospital Gazette.

VOL. III.—NO. 10. SATURDAY, DECEMBER 6, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

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THE BLOOD.

BY HENRY ASHBY.

THE LIQUOR SANGUINIS OR PLASMA.

The plasma is the fluid portion of the blood as it exist in the vascular system. It is not readily separated from the corpuscles in consequence of its tendency to coagulate on contact with foreign matter. It may be obtained in small quantities from the frog. Half-a-dozen frogs are selected, preferably those recently caught as they contain more blood, their heads snipped off and their trunks compressed, or the blood may be drawn directly from the heart into a test glass containing ½ p.c. solution of sugar, so that there shall be eqnal quantities of solution of sugar and blood. On filtering as rapidly as possible, the large corpuscles of the frog are retained on the filter, and the liquid which passes through, quickly coagulates into a clear firm jelly-like mass. If the blood be added to ½ p.c. solution of sodium sulphate in will not coagulate, if with ½ p.c. solution of salt, coagulation will be postponed.

This process will not answer for mammalian blood as the corpuscles are too small to be retained on the filter. The only method available, is to delay coagulation and allow the corpuscles to subside. This may be effected by diluting the blood with serum, or better still by means of cold. For this purpose a special apparatus is required consisting of three tin cylinders fitting inside one another, the outer and inner to be filled with pounded ice, and the intermediate cylinder to contain the freshly drawn blood, thus, exposing a large surface to the influence of a freezing temperature. The blood of the horse is selected as it coagulates less readily than the blood of the ox or dog, and the corpuscles more rapidly subside as they have a higher specific gravity than those of most other domestic animals.

Blood is drawn directly from the animal into the intermediate cylinder, and allowed to stand for several hours at the temperature of O°C. The corpuscles subside leaving a yellow liquid which may be drawn off with a pipette. On placing some of the plasma into a test glass, in a short time it will set into a solid mass resembling the setting of a solution of gelatine.

If this jelly-like coagulum be cut into pieces and washed in a current of water, a white fibrous opaque mass—fibrine—will be procured. Fibrin may be obtained from either blood or plasma by stirring with a rough stick and washing the strings of fibrin so formed for sometime in a continuous stream of water. If fibrin be acted on by very dilute HCl. at a temperature of 40°C. it will gradually swell out and be converted into acid-albumen or syntonin.

Fibrin is formed by the combination of two substances, *paraglobulin* or *fibrinoplastin* and *fibrinogen*. These substances belong to the class of bodies termed *globulins*. They resemble the albumens in their being coagulated by heat, and being converted into syntonin by dilute HCl., but differ from them in being precipitated from their solution by CO_2. To separate the constituent of fibrin, and to show that the formation of fibrin is a chemical and not a "vital" act, the plasma must be saturated with powdered NaCl. As the point of saturation approaches, a white flocculent precipitate appears. The liquid is thrown on a filter and washed with saturated solution of salt. It is dissolved in distilled water, filtered, and a clear liquid passes through, which yields a colourless coagulum on standing.

Paraglobulin can be readily obtained from serum. If serum of ox-blood be diluted ten times with distilled water and a stream of CO_2 passed through, a white granular looking precipitate of fibrinoplastic substance falls. This precipitate can be washed with water saturated with CO_2, and dissolved in distilled water.

Fibrinogen is best obtained from the liquid effused by uninflamed serous sacs. Pericardial fluid answers best. It is diluted ten times with distilled water and CO_2 passed through, a white precipitate resembling paraglobulin is thrown down. If this precipitate be washed and redissolved in water, and added to the solution of paraglobulin coagulation takes place readily at a temperature of the body. Acetic acid added in minute quantity short of acidity, will also throw down these substances.

Fibrinoplastic substance exists both in the serum and in the corpuscles.

Crystals of hæmoglobin possess similar properties of determining coagulation in fluids containing fibrinogen. A

blood-clot or clear serum added to hydrocele or pericardial fluid causes coagulation. It is not known in what proportion these substances combine to form fibrin, or even if they combine in atomic proportions at all. It has been suggested that fibrinogen is the fibrin former, and that the action of paraglobuline is merely catalytic.

The reason why coagulation should take place is not certainly made out. There are many different conditions which affect coagulation. Exposure to a temperature of $0^{\circ}C$ retards, while the temperature of the body accelerates. Contact with foreign matter, especially a number of rough surfaces quickly determines coagulation, whereas contact with the inner surfaces of the blood channels, although the life of the animal may be extinct, retards. The addition of water in considerable quantities, free acids, or alkalis, many neutral salts, as sodium phosphate and sodium sulphate, permanently prevent coagulation. But if blood so treated be placed in a dialyser, the salts be allowed to dialyse out coagulation will take place.

Brüche maintains it is the influence of the living blood vessel which prevents coagulation. This is not universally true, as it has been shown that blood does not coagulate in a glass tube which is connected with the aorta of a frog.

Blood yields from .02-.035 p.c. of fibrin (Lecanu).

The *serum* of blood is a light yellow clear liquid, containing the salts of the blood. These consist principally of sodium and potassium carbonates and phosphates, and small quantities of calcium and magnesium carbonates and phosphates.

Serum contains albumen, which may be separated in a pure state by precipitating with lead-acetate and decomposing by CO_2.

Serum-albumen differs from egg-albumen in not being precipitated by ether, and its more ready solubility in HNO_3. Egg-albumen injected into the veins appears in the urine. Serum-albumen does not pass out of the system.

(*To be continued.*)

TWO CASES OF POISONING BY "BURNETT'S DISINFECTANT,

By EDMUND AIKIN.

At 8.30 in the morning of Sunday, Nov. 16, Mr. W. swallowed, in mistake for Friedrichshall Water, a quantity of "Burnett's Disinfectant." The amount taken was, by subsequent measurement and calculation, ascertained to be about four fluid drachms, or about 50grs. of the solid Chloride of Zinc. He was immediately apprised of his mistake by a sense of strangulation and burning in the throat and stomach. As the handiest remedy, he at once swallowed a quantity of olive oil, and this together with warm milk and water, quickly induced copious vomiting. On visiting him half an hour after the administration of the poison, he was found in great pain, referred chiefly to the throat and stomach; vomiting incessantly, but without any signs of immediate collapse. Diluent drinks in the form of white-of-egg and water, and milk and water, were freely taken, and it was noticed that the albumen of the egg speedily returned coagulated. The vomiting slowly subsided, continuing at intervals during the rest of the day; and great tenderness in the region of the stomach was felt. There was no purging, if we except a slight watery evacuation during a violent fit of vomiting. The pulse never rose above 120, nor did the temperature exceed 100 deg. Fahr. Towards the end of the day he complained much of cold, but was in time relieved by warm wraps and a hot water bottle. Next day (Monday) the vomiting had nearly ceased, but extreme tenderness remained, and the fauces were seen to be very red. Iced water was directed to be taken during the day, with occasional teaspoonfuls of cold milk; and small doses of liq. opii sedat. every hour. An enema of half a pint of warm milk and 26 min. liq. opii sedat. was likewise administered. The following is the progress of the case:—

Tuesday, Nov. 18—The patient is certainly better, but is very much jaundiced from the violent vomiting. There is no action of the bowels. Urine very dark in colour. Pulse 115, temp. 99·5. Still very tender over the stomach. Throat less red. Is ordered to continue milk diet. Vomiting almost ceased.

Nov. 19—The tenderness is less, and the throat is less red and sore. Yellowness subsiding. To have a little chicken or mutton broth to be taken cold, in addition to the milk. Pulse 100, temp. 99.

Nov. 20—Is much better. To have an egg beaten up in the milk. Pulse 90, temp. 98.

Nov. 21—Still improving. Yellowness nearly gone, and but little tenderness remaining. There has been a great evacuation of slimy matter from the bowels; but no blood has been passed.

Nov. 22—Progressing favourably. Tenderness gone, and the fauces no longer red. Diet increased, but no stimulants allowed. A natural evacuation of the bowels. Urine natural in colour.

Nov, 23—Convalescent. Allowed fish.

A female servant at Mr. W.'s was attacked the same day and hour by symptoms of poisoning. She had imprudently tasted the contents of the glass; but swallowed only a very small quantity—probably not more than one fluid drachm.

The symptoms in her case were unexpectedly severe, and were probably to be accounted for by the fact that she could not induce vomiting until nearly an hour had elapsed. She was much purged, and appeared at one time to be in a state of collapse. The treatment was the same as in Mr. W.'s case. Her subsequent symptoms were slightly different, in that the pain was always referred to a small spot in the epigastric region, and that she suffered more or less uneasiness there every time food was swallowed. This is probably accounted for by the fact that, although much less of the poison had been taken; still the long period, which elapsed before vomiting set in, allowed the poison to exert a certain amount of corrosive action upon the gastric mucous membrane. She was, in consequence, kept for a longer period upon purely liquid food.

PHYSICAL SOCIETY.

The fifth meeting of the above society this session was held on Saturday last, Mr. R. C. Chicken in the chair.

Mr. J. Utting read a paper on "Germs—their History, and Connection with Disease," of which the following is an abstract:—

In giving the history of germs, the author first sketched the progress of knowledge connected with them, dwelling on the primary experiments of Redi in the 17th century, and then commenting on the experiments of Needham and the hypothesis of Buffon in the 18th century, which tended to contradict the deduction from Redi's experiments—that

all life proceeded from pre-existing matter, which contradiction by Needham fitted in with the hypothesis of Buffon, viz., that all living organisms were merely the combination, temporarily, of certain molecules, which molecules possessed the indefeasible property of life, and were themselves indestructible. The author then showed the defeat of this hypothesis by Spallanzain, who proved experimentally that germs existed, and that they were easily destroyed by heat; or further, that they might be filtered off from the air by cotton wool. He then went on to show that Tyndall had proved that the air contained germs, and that they might readily be discovered in the cotton wool which had served the purpose of a filter. He then detailed the experiments of Pasteur, exhibiting the type of apparatus which he had used in repeating these experiments, and showing by what arrangement it might he demonstrated that air contained living particles and organisms, demonstrating that—1st., Any fluid fit for the development of the lowest forms of life, but containing neither germs nor albuminous compounds, gave rise to living things in abundance, if exposed to ordinary air, while no such development took place if the air had been freed from the solid particles floating in it; 2nd., The great majority of particles are indestructible by heat, and that some of those particles are germs capable of giving rise to the same forms of life as those appearing in fluids exposed to unpurified air; 3rd., that inoculation of the experimental fluid by one drop of fluid known to contain germs gave rise to the same phenomena as exposure to unpurified air. The author then went on to comment on the comparative ease with which germs of the animal kingdom are conveyed through the air to those of the vegetable kingdom relating in full the experiments which led to the discovery of this fact. He next passed on to consider the zymotic diseases connected with the germ theory and then discussed fully the various methods of entry of germs into the system, and instanced some peculiar phenomena occurring in insects, which the microscope had revealed, in connection with this portion of his subject. After considering this section of the subject fully, he concluded, remarking that the surgeons whose operations were most successful, and the physicians who aided most in stamping out zymotic scourges, would be those who bore in mind the practical consequences attendant on the facts which he had brought before them.

In the absence of Mr. Paul, the debate was opened by

Mr. Hetley, who said he had nothing to say against the paper. Mr. Utting had given a comprehensive view of germs in general, but had not followed it by any practical suggestions. He thought that in surgical diseases, such as pyæmia, &c., germs need not be the exciting cause, as we did not know that germs would cause any specific irritation.

Mr. Bevan said that although in the bodies of diseased insects spores were sometimes found, yet in zymotic diseases we find no spores in the body; if these diseases were caused by spores we ought to find some disease of the viscera; in erysipelas we merely find some blood change. He referred to some experiments made by an Italian upon the value of sulphurous acid as a germ destroyer, and finally attributed the value of cotton wool dressings to the fact that the wounds were disturbed so seldom.

Mr. Cumberland Taylor asked Mr. Utting for an explanation of his experiment. He thought that after boiling a liquid germs might reform, and therefore after water was boiled to prevent cholera it ought to be kept protected from the air by plugging the filter with cotton wool. He also objected to the contrast between vegetable and animal substances in a state of decomposition with regard to the relative rates of germ-production, on the ground that germs probably did not thrive in alcoholic and especially acetic vapours as were present in the experiments. It would have been more satisfactory to have used vegetable substances in a state of decomposition instead of alcoholic and acetic fermenting liquids.

Mr. Lancaster referred to a letter in the *Lancet*, to the effect that flies had more to do with disease than was thought, especially diarrhœa and cholera.

Mr. Lamb had been much interested in Mr. Utting's paper; he had no doubt that germs existed, and that they were the cause of zymotic diseases, but doubted whether they were the cause of pyæmia With reference to the case where a patient had died from the bite of a fly, he thought that this result had more to do with the man's health.

Mr. Morton Palmer wished Mr. Utting had gone further; he had only given the texts, leaving the speakers to fill in the sermons. He considered that in exanthemata the blood had got into a bad state; need this state be due to the presence of particles? Dr. Budd had advised that to prevent infection the body should be anointed with oil. He thought there was no doubt that hay asthma was due to particles floating in the air. He mentioned a theory that measles was due to fungus, and referred to experiments where measles had even been produced by inoculating with the fungus. Some people said because they could not see germs, that therefore they did not exist, but the germs that could be seen were very small, and others might exist so small that they could not be seen.

Mr. Day had heard at the last meeting that the subject was too difficulty to be discussed; he thought the remark applied equally to the present subject. He suggested that zymotic diseases should be divided into two classes—those which were produced by germs, as typhoid, which might be called contagious; and those which were not, astyphus, which might be called infections. He did not agree with Mr. Lamb that pyæmia was constitutional, because the pyæmic abscesses were due to emboli, and septicæmia was due to lacteria acting on a disordered system.

Mr. Lamb explained that he meant that the reason in one case lacteria did produce pyæmia, and in another did not, was on account of constitutional disturbance.

Mr. Cumberland Taylor referred to the occasional occurrence of hay asthma in London.

Mr. Morton Palmer said that hay was sometimes brought to London.

Mr. Bond agreed with Mr. Lamb, that predisposition had much to do with the character that germs took on, or else we should all get hay asthma in the hay season. Mr. Utting had not explained how a surgeon could carry the germs from one patient to another.

Mr. Whitworth remarked that as we derived the antiseptic treatment from Pasteur's views, it would be interesting to know how he treated silkworms.

Mr. Blackmore thought that Lister's success was due to his personal superintendence of the dressings.

Mr. Lamb said the benefit of the antiseptic treatment was proved by the absence of erysipelas in the Assistant-Surgeon's beds.

Mr. Hetley did not remember a single instance of erysipelas following the antiseptic treatment since its introduction into the Hospital, and doubted whether in ever occurred.

Mr. Blackmore called Mr. Hetley's attention to No. 14, Lydia.

Mr. Vinter mentioned a case where erysipelas had followed an operation for necrosis (not antiseptic), on a

patient in whom it had not occurred after a previous (antiseptic) operation.

Mr. Whitworth said that sometimes erysipelas was due to careless dressing.

Mr. Cock instanced a case where it had occurred in a wound on the neck, where the dressings were difficult to apply. He made some remarks upon hay asthma.

The chairman doubted whether carbolic acid was antiseptic, he thought that cold water would do as well.

Mr, Utting having fully replied. A vote of thanks to him for his able paper was moved by Mr. Bevan, seconded by Mr. Harsant, and carried unanimously.

The chairman announced that the next paper would be read by Mr. Giblin, on the Turkish Bath.

MEDICAL WARDS.

—o—

The following cases were admitted from Nov 27 to Dec. 3, 1873.

MARY.

13—Bright's Disease
14—Bronchitis
17—Typhoid
20—Anæmia

STEPHEN

5—Morbus Cordis
7—Pleuritic Effusion—Bronchitis
10—Bronchitis—Albuminuria
12—Diabetes Mellitus
13—Chronic Rheumatism
14—Bronchitis—Emphysema—Albuminuria
29—Cerebral
44—Facial Erysipelas—Syphilis
45—Double dry Pleurisy

ADDISON.

24—Phthisis
25—Febricula ?
27—Chronic Pyæmia ?
27—Chlorosis Bronchitis
38—Chorea
39—Tumour of Eyelid

PHILIP

11—Epileptiform Seizure—Slow Heart
15—Stricture of Œsophagus—Carcinoma
34—Acute Rheumatism

MIRIAM (Clinical).

26—Lumbar Abscess
30—Tumour of Brain
29—Syphiloma of Brain

JOHN (Clinical).

2—Cerebral
4—Broncho-pneumonia

BRIGHT (PETERSHAM).

9—Slight Chlorosis
16—Sciatica ?
17—Ovarian Tumour
19—Subacute Rheumatism

SURGICAL WARDS

—o—

The following cases were admitted from Nov. 27 to Dec. 3, 1873.

CORNELIUS.

12—Contusion of Leg

LYDIA

4—Ulcer of Leg
6—Ovarian Disease

MARTHA

2—Right Femoral Hernia, (Strangulated, no operation)
6½-Scald of Trunk
8—Fracture of Base of Skull and Clavicle
22—Incised Wound of Neck

CHARITY.

4—Fracture of Jaw at Synphysis
8—Suppurating Wound, Left Knee-joint
27—Disease of Right Hip
28—Disease of Right Hip

DORCAS

3—Enlarged Bursa Patella
17—Necrosis after Amputation
27—Disease of Right Elbow-joint
28—Disease of Knee-joint

LUKE

1—Disease of Right Hip (Abscess)
4—Fistula in Ano
6—Sebaceous Cyst of Neck
9—Stricture of Urethra
15—Disease of Metatarso-phalangeal Joint of Great Toe
17—Hydrocele
19—Bronchocele

NAAMAN.

9—Amputation of Finger
14—Stricture of Urethra

JOB.

9—Ulcers of Legs

LAZARUS.

4—Retention of Urine, (Enlarged Prostate)
15—Hæmorrhoids
18—Stragulated Femoral Hernia (Operation)

ACCIDENT.

2—Comminuted Fracture of Metacarpal Bone
3—Fracture of Fibula
5—Comminuted Fracture of Olecranon
7—Disease of Carpus
13—Concussion of Brain
17—Fracture of Tibia and Fibula
17—Fracture of Femur
31—Blood Swelling after Contusion

THE OPERATING THEATRE.

—o—

November 25.

ANEURISM AT THE LOWER BORDER OF THE HIGHT POPLITEAL SPACE, TREATED BY THE INTRODUCTION OF HORSE HAIR INTO THE SAC.

Mr. Bryant remarked that the aneurism was of some standing, its

presence having been recognised six or seven months ago by the patient who was an unfortunate subject for the ordinary modes of treatment, since he suffered from mitral disease of the heart, and undoubtedly had very bad arteries; and, although no other aneurism had been discovered by a careful search, still one might exist unknown, for instance in the thoracic cavity. Pressure had already been tried for a fortnight or three weeks off and on: but the only effect of this had been to harden the aneurism, showing that some coagulation had taken place on the walls of the sac, but not sufficient to cure it. He was unable to bear any further pressure. During the pressure he suffered from epistaxis, but this was not due to the aneurism, but rather to the mitral regurgitation. However it pulled him down a good deal, so we were led to try the treatment by secale, recommended by Langenbeck; but, though it improved the pulse, and stopped the epistaxis, the aneurism was evidently increasing in size, indeed during the last three days it had become half as large again as it was when the man was admitted. Under such circumstances it is clear something must be done. Pressure has been tried, and has not succeeded. The heart and arterial disease contraindicated the application of a ligature; therefore, I have determined to tap the aneurism with a trochar and canula, and pass horse hair into the sac. The object of this treatment is that the blood may coagulate round the hair, and so fill up the aneurism. The idea is not one of my own; it was first introduced by the late Mr. Moore, of the Middlesex Hospital, who passed a quantity of wire into a thoracic aneurism; and I have recently had communicated to me by Mr. Terris, of Philadelphia, a case of aneurism of the right subclavian and axillary artery successfully treated by the introduction of horse-hair. I though that such a mode of treatment would be suitable to this case.

Mr. Bryant then introduced a very fine trochar and canula, and, withdrawing the former, he proceeded to pass through the canula about 18ft. of horse-hair. This was accomplished in a few minutes, three threads of hair being pushed in together. Blood flowed through the canula, though the artery was compressed, till the end of the operation when it ceased; and, when the canula was withdrawn, there was no bleeding from the wound, which was closed with some of Mr. Bryant's mackintosh strapping. The leg was covered with cotton wood, and the patient removed to the ward, the aneurism still pulsating, but not so strongly.

REVIEWS.

HINTS ON OPHTHALMIC OUT-PATIENT PRACTICE.*

The same sad experience, which led us a short time ago to urge a better attendance of students in the Eye Department, leads us now to welcome this little book with an unusual amount of interest. We then pointed out some of the gross errors committed by those who had neglected to study the diseases of the eye, and the unfortunate circumstances they sometimes led to. We are glad to have so soon found a ready means by which such negligences may be greatly remedied. Mr. Higgens has done good service in the cause of Ophthalmic Surgery, in that department which most required help—the common cases treated by the general practitioner. Already there were two classes of literature on this subject; one, a short account of the principle operations on, and affections of, the eye in our text-books on Surgery, the other, a form only suited to specialists. But the general student was benefitted almost as little by the former as the latter; for, not intending to operate on the eye, he practically gained very little from such an account, beyond a knowledge of how to treat iritis and ophthalmia; and none but dressers in the Eye Wards would have learnt, when they left the Hospital, the advantages of the ophthalmoscope how to find spectacles for the abnormal refractions of the eye, and a hundred other little practical points, which would have assisted them every day in their practice. We consider these "Hints" excellently calculated to generalise the practical knowledge of eye diseases, formerly only acquired by dressers in the Eye Wards, and though, by Mr. Higgens' original intention, they were "written expressly for Dressers in the Eye Wards," we would recommend them expressly to those who had *neglected* to hold that appointment, for they consist of a short resumé of what he teaches his dressers during their four months' duty, written in such a plain and concise form, that not only are the diagnosis and treatment of the common diseases of the eye given, but the use of the ophthalmoscope, and the way to find spectacles for hypermetropia, myopia, and presbyopia are also easily to be learnt by any one from these few pages.

* HINTS ON OPHTHALMIC OUT-PATIENT PRACTICE. By CHAS. HIGGENS, F.R.C.S., Assistant Ophthalmic Surgeon, Guy's Hospital. London: O. G. Brimmer.

THE PROGRESS OF MEDICINE.*

We have before us, as a little book, the printed lecture introductory to the present session, delivered at the London Hospital. Instead of attempting to force the whole width and extent of his subject into so small a space, Dr. James contents himself with sketching the part which the London Hospital men have taken in the The Progress, and telling how, but for accidental circumstances, their sphere of renown might have become more widespread. To those whose sympathies are with the London Hospital, the book will be very interesting: to all it will be instructive; but the younger the student is in his curriculum, and the less interest he takes in the East London *Alma Mater*, the less love he will feel for those great men whose names are mentioned. We have read the book with pleasure, but the feeling would have been more intense had the author been more gentle in taking the wind from the sails of inventors and discoverers who now are dead. It is often impossible to assign improvements, &c., to their true originators. Often the whole credit of an invention is due to a hint that one has heard thrown out by another, and often a man, who says he has predicted a thing, attempts to draw the honour and glory from another who has done all the hard thinking and working necessary to elaborate the scheme. The book closes with many thoughts and precepts that seem true to us, and we think that the lecture has wisely been printed, as it is calculated to be of greater interest to those whose curriculum is finished, than to the students whom Dr. James was introducing to their Hospital.

* THE PROGRESS OF MEDICINE. By M. PROSSER JAMES, M.D., M.R.C.P. London: Balliere, Tindall and Cox.

CORRESPONDENCE.

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents*]

To the Editor.

Sir,—In publishing the two appended cases of poisoning

by "Burnett's Disinfectant" (Chloride of Zinc), I am sure you will be doing good service in ventilating the danger of keeping so dangerous a fluid in private houses. It may be an excellent disinfectant, and, no doubt, is very largely used with good results; but it has the great disadvantage of being undistinguishable, either by its colour or its smell, from drinking water or from any other colourless or scentless solution. All the other fluids used as disinfectants or deodorisers (with the exception, perhaps, of Chloralum—which is harmless) have some unmistakable mark to indicate their presence; "Condy's Fluid" has its colour, Carbolic acid, Chloride of Lime and the rest—their smell. In large institutions "Burnett's" Disinfectant may be, and doubtless is, used with great advantage; owing to its cheapness and portability. But in such establishments proper precautions can be taken against its applicatlon to any other than its own proper purposes.

I remain, Sir,
Yours obediently,
EDMUND AIKIN.

P.S.—Should any further symptoms present themselves in either of these cases, I will take care to inform the readers of the Gazette.

To the Editor.

Sir,—As we are responsible to the Treasurer and Governors of the Hospital for what occurs in the Surgery throughout the day and night, we think it only right that the letter of "A.," which appeared in your last issue, should not remain unanswered.

Who the anonymous correspondent was, or what his "hour of need," we do not know, but we feel sure that old Guy's men as a rule would much prefer to hold themselves prepared for any emergency whatever, for it is obvious that in seeking such assistance from their old Hospital they cannot help robbing a public institution.

If one were allowed to take a roll of strapping, any old Guy's student might claim an equal privilege, and the precedent commenced by giving strapping might in time be extended to splints and instruments also.

If the behaviour of "the Dresser" was needlessly uncivil we are far from wishing to justify it; we only desire to disclaim in future, as far as we are concerned, the assumption of any such privilege as "A." seems to think belongs naturally to old Guy's men.

We are, Sir,
Yours, &c.,
J. LACEY MORLEY, Senior House Surgeon.
W. H. A. JACOBSON, Junior House Surgeon.

Guy's Hospital, Dec. 4.

P.S.—In writing the above we have neither desire nor intention of entering upon any further correspondence on the subject, but it may be well to add that the strapping appears to have been taken by "A.," the nurse denying altogether that she gave it to him.

Our attention has been directed to an error in a notice of some of the newer surgical instruments exhibited in the International Exhibition, which was given in our issue of Sept. 27. The flexible coil probes were described as the suggestion of Mr. F. E. Manby (the initials then on the namo plate), whereas Surgery is indebted to Mr. A. R. Manby for this exceedingly usefnl little instrument, a specimen of which has been sent us for inspection; and we are very pleased to find that a practical acquaintance with it tends to strengthen the favourable opinion which we then expressed respecting it.

HAPPINESS.

Huxley says, "I take it, that the good of mankind means the attainment by every means of all the happiness which he can enjoy withou diminishing the happiness of his fellow-men." A very guarded formula, not assuming the possibility of one's raising the happiness of one's fellows. It speaks of men and happiness; but it leaves unsaid anything about the time of developments in a "man" that is to be taken. Is it the childhood of the man that is to be chosen to see whether it is happy, or is it his adult age? But when is he adult? Is a first year's man adult? Is a man ever so in some cases?

The attainment! But when do we attain and enjoy? The proposition, you see is too static, and does'nt seem to work with a moving world of people in different ages and stages. All the Happiness that I can think of includes an undefined—and so unlimited—future, and that only belongs to Youth. Nay! only to youth while full of zeal and faith.

In such definitions you assume that a man can be filled, and so you leave out of account that undefined and insatiable desire which makes you, for instance, take up these large questions. The "happiness," in Huxley's definition, seems to get all it can for itself in a fair way of trade. But you will find out in time—First, that true happiness is happiness which you can enjoy with others; and Second, that wise happiness is happiness whose source will still bring happiness at all other times and in all other places.

PILOCEREUS SENILIS.

Entering on the last month of the year, we are reminded that Christmas is near: and among the pleasures it brings with it we must not forget that of contributing to provide something of a Christmas dinner for the patients in our Wards. For many years the students havo been in the habit of raising a sum amongst themselves for this purpose, and we feel sure that nene will grudge his shilling or half crown whether his work leads him habitually ihto the wards or not The House Surgeons and House Physicians have usually undertaken the woek of collecting, assisted by one or two other students, and we hope to be able next week to give the names of those to whom subscriptions may be given.

FOOTBALL CLUB.

GUY'S v. CLAPHAM ROVERS.

This match was played at Balham, last Saturday, and we were again victories by three goals and fonr touch downs to nothing. We won the toss and in the rain, the Rovers' Captain kicked off, but the ball was soon returned into their quarters where it remained, until Pearson by a magnificent drop, sent the ball over the Rovers' goal, The ball was again started, and after a few minutes play, Finch, who was as usual, in great form, ran in and touched the ball down between the posts, this Pearson converted into a goal; shortly after this Hetley obtained another try, and Pearson by a fine kick, placed another goal to our credit. After half-time, we still penned our opponents, but nothing of importance occurred, excepting that Gray having made his mark, by a splendid drop nearly secured another goal for us, the ball passing about half a yard to one side. Thus ended a very pleasant match in which all our men played remarkably well against one of the best teams

in London. The following played for Guy's:—Captain —Robson; backs—A. W. Pearson and C. MacKern; three-quarter back—Gray; half backs—Pinch and Day; Breach, Gibb, Gilbert, Rendall, Hetley, H. Duke, Wells, Brown and Wallis.

GUY'S (II. Fifteen) v. GRASSHOPPERS.

The above match was played at Blackheath, on Saturday last, November 29th, Guy's winning by one goal and a fine touch down to nothing. Shortly before time was called Smart ran in with the ball, and Collins succeeded in obtaining a goal by a good place kick. All the Guy's men played up well, while Woodley, Fitzgerald, Montague, and Soles distinguished themselves for the Grasshoppers. The following fifteens played:—A. Carey (caotain), Poland und Maltby (backs), Smart and Johnson (half backs) Mutch, Collins, Wilkinson, Duke, Porter, Perry, Mainwaring, Roberts, Womersley, Levein.

MATCHES THIS DAY.

First Fifteen *v.* King's College Hospital, at Blackheath; Second Fifteen *v.* Southgate F.C., at Southgate.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

ANSWERS TO CORRESPONDENTS.

M.D.—We cannot undertake to publish matter unaccompanied by the author's name, (not necessaily for publication).

GUY'S GLEE CLUB.

THE ANNUAL CONCERT (in aid of the Samaritan Fund), under the patronage of the Treasurer and Governers. will be given on TUESDAY, DEC. 19th, in the GOVERNORS' COURT ROOM.

The following Gentlemen will take part:—Messrs. A. de W. Baker, C. E. Bell, W. Grey, C. J. C. Mitchell, W. G. Nash, J. H. Poland, R. J. Pye-Smith, L. Rudd, A. Sangster, H. N. Smith, S. J. Wilding, H. Wright.

Tickets, 3/- Each, may be obtained on application, personal or by letter, at the Steward's Office, where a plan of the room is to be seen.

LEONARD RUDD,
Hon. Sec.

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"We consider these "Hints" excellently calculated to generalise the practical knowledge of eye diseases formerly only acquired by dressers in the Eye Wards, and though, by Mr. Higgen's original intention, they were "written expressly for Dressers in the Eye Wards," we would recommend them expressly to those who have neglected to hold that appointment, for they consist of a short resumé of what he teaches his dressers during their four months' duty, written in such a plain and concise form, that not only are the diagnosis and treatment of the common diseases of the eye given, but the use of the ophthalmoscope, and the way to find spectacles for hypermetropia, myopia, and presbyopia are also easily to be learnt by any one from these few pages."—GUY'S HOSPITAL GAZETTE.

LONDON: O. G BRIMMER, 104, BOROUGH, S.E.

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The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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Mr. Bryant's Nasal Polypus Snare.
Mr. Wagstaffe's Bulbous Catheters.
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Guy's Hospital Gazette.

VOL. III.—NO. 11. SATURDAY, DECEMBER 13, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

—o—

THE BLOOD.

BY HENRY ASHBY.

GASES OF THE BLOOD.

These are Oxygen, Carbonic Acid, and Nitrogen. The first tolerably accurate analyses of the gases of the blood were made by Bernard. He measured the oxygen by displacement with carbonic oxide. Having introduced the blood into a tube over mercury, the carbonic oxide is added, and the blood and gas agitated together. The oxygen of the hæmoglobin is completely, and the other gases partially, replaced by the carbonic oxide. The free oxygen is then absorbed by a solution of pyro-gallic acid, and the carbonic acid by potash, and the space they occupied measured. This is a fairly accurate method for the estimation of oxygen, but not applicable for the other gases as they are but imfectly replaced by carbonic oxide.

Ludwig's method, now universally employed, where exact results are required, consists in submitting the blood to the Torricellian vacuum. This process yields results far superior to Bernard's.

One hundred volumes of arterial blood yield to the Torricellian vacuum at 760 millimetres and 0°C twenty volumes of oxygen, and venous blood twelve volumes. This oxygen is nearly all in combination with hæmoglobin. It is not simply dissolved, as in spring water. In water containing gases, and submitted to diminished atmospheric pressure, the gases are disengaged as the pressure diminishes in accordance with Dalton's law. But the oxygen of the blood is not given off until the pressure sinks to $\frac{1}{6}$th of an atmosphere. Blood thus submitted to the vacuum is dark in colour from the reduction of the hæmoglobin to the state in which it occurs in venous blood. The same result occurs when submitted to the action of carbonic oxide, carbonic acid or other atmosphere containing no oxygen. Carbonic oxide differs from most other gases in replacing the oxygen and forming a new compound with hæmoglobin resembling the oxy-hæmoglobin in colour and action on light.

One hundred volumes of arterial blood contain 35 volumes of carbonic acid gas, venous blood 43 volumes, and asphyxiated blood 50 volumes. The serum of blood yields as much carbonic acid as a corresponding volume of blood. From this, it is evident, the carbonic acid exists in the serum and not in the corpuscles. The carbonic acid, in common with many other gases, reduces but does not combine with hæmoglobin, thus differing from carbonic oxide. Some of the carbonic acid is in solution in the serum, but principally combined with the sodium carbonates, and perhaps sodium phosphates.

Bernard thought that he could make the corpuscles absorb more carbonic acid than the serum, and consequently affirmed that the corpuscles were the principal carriers of carbonic acid and underwent change of shape. When frogs' blood is submitted to the action of CO_2 under the microscope, the nuclei become more distinct, and the shrivelled corpuscles become more distended. That carbonic acid affects the colour and influences the corpuscles there can be no doubt, but the majority of observers believe that the carbonic acid of the blood exists as such in the serum.

THOUGHTS ABOUT CARBOLIC ACID DRESSING.

BY THOMAS EASTES, LATE HOUSE-SURGEON.

Whilst I had the Surgical in-patients under my observation, for part of the present year, I tried to satisfy myself as to the exact position which the above-named mode of dressing held, as regards results; and now, perhaps, it may be useful to some, if I state the impressions made on my mind. I will enumerate, as well as I can, what seemed to me the advantages and the disadvantages which may attend carbolic acid dressing.

The advantages—(1) generally less traumatic fever three or four days after injury, or operation; (2) suppuration does not tend to spread so much in wounds of the hand, wrist, &c.; (3) very much less risk of erysipelas; (4) much less risk of pyæmia; (5) very slight risk in opening joints or bursæ. In confirmation of the last point, one knee-joint was tapped twice with an interval of about six weeks; another was tapped once, and melon-seed bodies were removed from a wrist once, the incision entirely dividing the

annular ligament of the wrist-joint; all with good results. I consider the fact that joints are now opened almost with impunity, a positive proof that carbolic acid treatment is beneficial; and more important as establishing it as good practice in certain cases, than any amount of statistics.

The disadvantages—(1) operations always take longer; this now-a-days implies a larger dose of chloroform, an important item in modern Surgery, and one not, as I think, sufficiently taken into consideration; (2) healing is retarded, consequently cases are much longer before they can leave the Hospital, or even get up and out for a little fresh air: (3) the vitality of the flaps is lessened; (4) there is frequently a spray acting as a refrigerator to a large part of the body, very greatly adding to the collapse from the operation itself. In operations for hernia it is not unusual for a spray-producer to be playing on the greater part of the abdomen for half an hour, which must be injurious. The carbolic acid lotion is always intended to be hot; but, for how long, during an operation, is the spray warmer than the surface of the patient's body? This defect could proba ly be in great part remedied, but I am speaking of what we *have* seen, and not of what we *may* see. With regard to the third disadvantage, it struck me that when the blood was all forced out of a part, as in Esmarch's procedure, the cooling process of the spray was especially injurious. There is one other rare disadvantage, which I ought to mention, and that is (5) the absorption of the acid, causing symptoms of carbolic acid poisoning. I only saw one case of this, and that was not strongly marked. The patient was a child in No. 15 bed, Lydia Ward, with bed sores and sinuses communicating with a diseased hip-joint which were dressed with carbolic oil; for some days he was drowsy and listless, and, on one occasion, I saw the urine very dark from the carbolic acid. I should like to know, if more cases of melanuria occur with the use of carbolic oil than with the use of the lotion. The oil has always been in use in the few cases I have known. I heard it stated once that when a patient is in a very depressed state, and undergoing an amputation, the spray may be absorbed to a sufficient extent to hasten on the fatal result; and in consequence of this danger, one amputation, instead of being performed with the spray at work, was not treated antiseptically till the operation was completed, when the stump was dressed in the usual antiseptic method. In compound fractures the antiseptic dressing is not so effectual in warding off pyæmia, as in amputations, but its power against erysipelas does not seem much diminished. Perhaps simple decomposition and absorption may cause pyæmia, but something more specific, which abounds where there are open decomposing wounds, is required to cause erysipelas; and, therefore, when compound fractures are treated antiseptically, immediately on their entering a more or less poisoned atmosphere, the specific poison is kept off, but the bad results of the entry of ordinary air, prior to admission, cannot be entirely prevented.

In conclusion, I may say the advantages seem to outweigh the disadvantages, as being points of greater importance; and I also think that, by care and attention to small points, the disadvantages will be much lessened. Although we so often hear the advantages of antiseptic dressing enumerated, one after another, by its supporters, we rarely hear it objected to, in the same systematic manner; but sweeping assertions are more often made against it, such as "unnecessary trouble," or "we get equally good results without it." It is with the idea of comparing the two sides of the question more fairly, that I have put my thoughts on paper.

A CASE OF COMPOUND FRACTURE OF THE TIBIA AND FIBULA, WITH REMARKS.

BY H. WILLIAMS.

D. C., æt. 17, a labourer, was admitted into Accident Ward under the care of *Mr. Birkett*, on February 19th, 1873.

He was in Hospital two years ago with a fractured clavicle.

A few minutes before admission, he was knocked down by a blow on the back from a beam, and he says his left leg was doubled under him.

On admission—There is a compound fracture of left tibia and fibula, the protruding upper fragment of tibia can be distinctly felt through his trousers; the wound is two inches long, situated on the front of leg about the junction of middle and lower third, its direction is downwards and inwards, and its lower edge is overlapped and much bruised by the protruding tibia. The fracture is not comminuted and almost transverse in direction. The periosteum is stripped off the upper fragment of tibia to the extent of ¾in., though the bone is visible for at least 1½in. There is no hæmorrhage of importance, both tibials pulsate freely, and there does not seem to be any blood effused into tissues about the injury.

The patient was suffering intense pain from the protruding bone, and the muscular spasm in the calf of the leg, so it was thought advisable to give chloroform while the limb was put up. The man being fully under the drug, I endeavoured by very forcible extension to replace the bone in position, but in vain. Traction on the foot with the leg in different positions also failed in freeing the tightly trapped lower edge of the wound. I then divided the tendo achillis, and the effect of its division was almost magical; with the slightest possible extension the skin was freed, the protruding bone returned beneath it and placed in opposition with the lower fragment. The leg was swung on a back splint with two straight side splints, being confined to the back splint by two bandages, one lightly applied round the footpiece and instep, and the other round the splint and upper third of leg and knee. No strapping was used. A pad of lint steeped in carbolic oil (1-20), was lightly placed over the wound. Had ¼ gr. morph. acet. injected subcutaneously in the evening.

Feb. 20—As he complained of pain in his leg which he says is due to its swinging position, I took it off the swing and rested it on the bed. Half-an-hour after he said it had been free from pain ever since the alteration. He slept fairly during the night. Temp. 101, pulse 84.

Feb. 21—Temp. 102·5, pulse 116. Sleeps well, eats well

Feb. 24—Temp. 99·8, pulse 92. Leg easy, bowels open, tongue clean and moist, sleeps well, appetite good. The wound and the bruised skin around it are sloughing. Carbolic acid lotion lightly applied twice daily.

Feb. 26—Temp. 98·8, pulse 92. I made an incision to let out some semi-purulent fluid below and on the outer side of old wound.

Feb. 28—Sloughs have separated, leaving the lower end of upper fragment of tibia exposed for about 2in., with the lower fragment underneath it, and somewhat overridden; the latter is laid bare for about 1½in. A little manipulation brought the fractured ends into almost perfect position, the two serrated surfaces dovetailing into each other very prettily. Owing to the loosenesss of the parts, and their free mobility on each other, this position could not be kept, so by the advice of Mr. Birkett, the House Surgeon bored a hole in each fragment near its inner border,

then passed a strand of silver wire through them both, piercing the anterior surface of the upper fragment from before backwards and coming out of the hole in the lower fragment, from behind forwards, the two ends of the wire were then twisted together. This contrivance kept the bones in capital position from which they never moved. Temp. 98·6.

March 3—Leg keeps in good position; the wound which is about four times its original size is rapidly cleaning and healthy granulations are appearing. General health good.

March 9—A red and painful blush appeared yesterday on inside of lower third of thigh just above the splint, it was joined to the wound by a red and tender line; glands in scarpa's triangle swollen and tender. His appetite is not so good, no other constitutional symptom, tongue thickly furred. He was ordered Pulv. Emeticus 10 grs. statim. Vomited twice after the powder.

March 10—Blush has almost gone and the glands are smaller and less painful. Tongue cleaner. To have Tr. Ferri Per. 20m., Ex Inf. Quassiæ 1 oz. t. d. Patient in bed to the left of him, and one on opposite side of ward have erysipelas Leg is in good position, granulations healthy and healing, and creeping fast down the exposed bone. Appetite good, bowels open.

March 14—Drawing taken of leg this morning.

March 27—Nothing of note has occurred since last report, but to-day the bare bone is felt to be loose, so I removed it, having to cut the suture to do so; the extent of upper fragment removed corresponded with that of the protruding bone on admission, it is only a shell of the anterior surface of the tibia; under it was a layer of healthy granulations. The exposed surface of the lower fragment is not at all loose. Leg is wonderfully strong and in capital position. Discharge from wound copious and healthy.

March 30—This morning I transplanted six pieces of skin on to outer border of wound, about ¾in. from the edge.

April 3—All the grafts but one appear to have taken. As the granulations are exuberant and the discharge copious, I have dressed to-day with dry lint.

April 7—To-day I removed the exposed portion of the lower fragment, eleven days after the upper one.

April 19—Patient gets up daily now, but does not put his foot to the ground. Wound is rapidly healing. Union of bones very firm and strong.

Patient was discharged about a fortnight after this, with the wound all but well; on passing fingers down the front of tibia, it was impossible to tell there had been a fracture. No shortening. Tendo achillis has been united and in use for a week or two; patient has never suspected that anything was done to his heel.

To be continued.

CLINICAL LECTURE.

—o—

BY DR. WILKS.

November 29, 1873.

Gentlemen,—We have had some very interesting cases in this week. Typical cases—cases that illustrate well-marked forms of disease, of which, if you have got notes, will be of use to you as long as you live. Before, however, proceeding to these, I wish in fairness to one of my clerks to make some allusion to one of the cases I had in last week. A woman was admitted having a tumour that felt like a pregnant uterus, but on examining per vaginum the uterus was found to be healthy. If I had read the report I should have come to the same conclusion as Mr. Williams, who had already formed a capital diagnosis of the case. I was told that she had had acute symptoms, but I did not pay sufficient attention to the history. You will find this when you get into practice, that the history is often so indefinite that we get in the habit of disregarding it. My clerk had gone into this case, and he was satisfied that the woman was well until two or three weeks previously, that then she was attacked with feverishness and rigors, and that suppuration was going on in the body, and that the tumour, therefore, was an abscess. On making further enquiry he found that she had had a fall and had injured herself at that part. He naturally concluded, therefore, that she had injured her abdominal walls, blood was effused, and subsequently suppuration had occurred, thus accounting for all the symptoms. He put all these facts together, I say, and came to the conclusion that she had an abscess forming in the abdominal walls as a consequence of ruptured muscle. I told you, then, that we wanted a diagnosis, but at the same time the diagnosis had been made, and admirably made by the clerk. It was only yesterday that we opened the tumour, and there we found matter and blood, as he had suggested we probably should.

The next case is one of intussusception. This is a case you ought to know thoroughly all about, because you will not be in practice long before you see similar cases. It is a curable disease, although we were unfortunate enough not to cure this child. We take special interest in these cases in this Hospital, because one of the earliest papers on the subject was written by a Guy's man—Mr. Gorham, of Tunbridge, in Vol. 3 of the Reports. The present case occurred in a child, aged about six months. The night before admission it was evident the child was ill. It was shrieking and crying out. On the following morning it was noticed that his napkin was stained with blood. Now think of that, because it is one of the most important points of the case.

Then, you remember, when we went into the ward we saw the child lying nits mother's lap, evidently in great pain, its legs curled up. It had been sick, and nothing had passed through it. It was clear, therefore, there was some mechanical obstruction of the gut, and as the most common form is intussusception, we thought of this first. On putting my hand upon the abdomen, a little above the umbilicus, and a little towards the right side, I felt a lump. Then, on keeping my hand upon it I thought I felt it move and contract. If, with the symptoms I have described, you find a lump, and feel that lump contract you may be pretty well sure it is intussusception. The most common form is a piece of the ileum passing into the cœcum. It is a disease very common in infants, and very uncommon in adults. I have seen two cases in young men, but never in grown-up persons. The ileum, I say, generally passes into the cœcum, and you see for this reason—there is a constant peristaltic action going on, and there is the large intestine, larger than the small, so that it seems natural the latter should pass into the former, and this tendency is further assisted by the large intestine being fixed. I have no doubt it occurs oftener than we think, but it passes out again and there are no other symptoms. At times, however, it goes on and on until it may pass down into the rectum, and may even come out, so that in some instances you may see the intestine

protruded externally. If you cannot see it you may some times feel it, and you know it is intussusception by this —you pass your finger into the rectum, and you feel the soft mucous membrane of the gut with a hole in the centre, or as the older writers called it "a rose-bud." The symptoms are those of strangulation as a rule, that is vomiting and no passage through the gut. But you must remember that the gut is hollow. It is still open, and there is no obstruction. Therefore it is possible that you may have one large piece of intestine pass through another, and yet remain open, so that fœcal matter shall pass through for weeks and weeks; and then the whole piece of intestine may slough off. Why there is obstruction is because of the mesentery dragging upon it; so that if you look at a portion of intestine which has passed into another you find it dragged on one side. That is why obstruction occurs, otherwise the opening remaining there you need not have insuperable constipation. Supposing the stoppage to occur from a band you have simple obstruction, but in these cases of intussusception, on account of the dragging, you get the mucous membrane torn and then blood passes, and this is a most important sign, so much so that if you get symptoms of obstruction, with the passage of blood, you may be sure it is intussusception. In practice you will often find this the first symptom, observed by the mother in this case; and then, when you put your hand on the abdomen, you feel the lump, and in placing your hand on the tumour you feel it move. The fact of putting the hand on the abdomen will increase the action.

Then as to treatment. The case is of interest, I say, because we can cure these children. What we have to do is to get it bach again, and there can be only one mode. It would be dangerous to pass anything up, because you do not know how far it might go, or what damage you might do. The treatment is to distend the bowel. Last year we had a similar case, in which we inflated the bowel and cured the child. There is some little difficulty in preventing the air escaping, but you take a pair of bellows and pass the nozzle into the rectum, making it as air-tight as you can with lint, and gradually inflate the intestine; at the same time place your hand on the abdomen, and you feel the bowel go back, sometimes almost with a snap. In the case of a child seven or eight years old they may express immediate relief. In the present case we were just about doing this when Mr. Durham came into the ward, and he suggested oil. Well, oil was used, and the intestine went back as far as it could be felt, and the child appeared to be relieved, but there was still a small lump felt by some. Then the bowel appeared to come down again, and another attempt was made. On the following morning the child was a little better, but there were still symptoms, and Mr. Howse was asked to see it, and distension was performed a third time. It was hoped the child had been relieved, but it died, however, on the following morning. At the P.M. it was found it had gone back to a certain extent, but not altogether. An attempt, I am told, was made to return it after death, but it was found impossible on account of the adhesions which had formed. And this constitutes the difficulty. You cannot tell how long it has been invaginated, and whether it is capable of being put back. If perfect strangulation has occurred, Nature's cure is to get rid of the invaginated portion, seal together the two ends, thus restoring the patency of the canal. The first step of this process is the formation of adhesions, so that when the piece has sloughed away the tube shall be perfect. There are some remarkable cases of this in our museum. In one or two days such adhesions may have formed, that it would be impossible to unravel it such was the case here. It had been unravelled to a certain extent but not altogether. Then something else can be done, but I do not know how far that may be advised. I refer to opening the abdomen, and searching for the cause. I used to say that nothing justified us in doing it. The chances are remote in both cases, but I always thought they were rather better when left alone. Last week, however, I saw Mr. Hutchinson brought a case of this kind before the Medico-Chirurgical Society, where he had opened the abdomen, drawn out the invaginated portion, and the child recovered.

(From the *Medical Press and Circular*.)

ADULTERATED CIGARS.—According to a Vienna contemporary, German cigars are even worse than those sold in this country. All sorts of solid substances may be found rolled up in the leaf of the fragrant weed. The writer states that within his own observations the following have been found:—Bristles, hairs, wood, bits of linen and of leather, needles, shirt-buttons, and teeth. These substances glowing in the smoker's cigar must astonish him. Throgh the middle of one a goose's feather was drawn from point to end. In another was a cord, and a third, a match. These are all adulterations which, apart from their aroma, at the most, could only occasion nausea or vomiting. But far worse and more dangerous are those which conceal exploding materials. These are the so called "explosive cigars" manufactured as "jokes" and not unfrequently the cause of severe accidents. Cases have been reported where sight has been totally dsstroyed. We advise smokers to take care what they buy—particularly in Germany.

SERVANTS' SICKNESS.—We suppose that in these days of dear food and fuel not a few of our readers would be glad to retrench, but are prevented by the extravagance of their servants. A correspondent of a paper mostly supported we believe by ladies—the *Queen*, offers servants some good advice as to their food, teling them that in consequence of consuming an excessive quantity of animal food, or "butcher's meat," they bring their blood into a bad state and injure their constitutions. This is the cause of so many servants becoming weak in their legs, which infirmity they are too ready to attribute to hard work, and finally they break down altogether. Servants who have a reasonable amount of work, with moderate fare, are generally in better health than the "pampered menials" who live sumptuously and have little to do. Even the less fortunate members of the working classes, who really work hard, and taste meat perhaps not more than once a week, are usually stronger and in better health than the domestic servant who has three meals per day with stout or ale *ad libitum*. In hospitals there is disorder called the "Servants' Sickness," which is caused by excessive indulgence in animal food by servants who have previously lived almost starvingly in poor homes. The objection amongst the ignorant classes to vegetable diet is wide-spread; they have an equal dislike to farinaceous food and to "vegetables," commonly so-called; they despise a dish, of which vegetables form a part; they will condescend to eat pudding as an extra—a luxury—but they take care to satisfy the appetite with meat before pudding time. If they are ordered a curried dish, they regard the rice as a garnish, and cannot be persuaded to partake of it as a part of the meal. The picture thus presented is no doubt one constantly met with among gluttonous and beer-drinking servants who are not overworked, and just as brewers men are notoriously bad subjects when attacked by disease, so are such "pampered menials." In that sense the term "Servants' Sickness" may be admissible, though it is hardly to be said that this constitutes a disease. Excess in eating and drinking is too common in many classes, and the results are always such

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

Examination for the Licence (Second Part, or Pass).

December, 1873.

Medical Anatomy and the Principles and Practice of Medicine.

1. Describe a case of Strumous Meningitis (Acute Hydrocephalus), and point out the characters by which it is distinguished from Infantile Fever.

2. In Acute Pneumonia, what circumstances indicate the presence of Pleurisy, and what the existence of Bronchitis, as complications of the primary disease?

3. Give the diagnosis between Painters' Colic, passing Gall-stones, and Calculus in the Ureter.

4. Describe the Anatomical relations of the Nerves and Great Vessels in consequence of which Aneurism in the Chest is liable to affect the Larynx.

5. Enumerate the precautions which you would recommend to be taken to check the spread of an Epidemic of Small-pox.

6. Describe the treatment of a case of Typhoid (Enteric) Fever —from the earliest stage to complete convalescence.

Materia Medica, and Chemistry, in their applications to Pathology, Pharmacy, and Toxicology.

1. Name the Salts of Potash in the Pharmacopœia, describe the Medicinal effects of each, and specify those which have the power of making the Urine Alkaline. How is Liquor Potassa prepared?

2. Mention the Officinal Plants in the order Solanaceæ. Whence is Digitalis derived? Describe its Physiological and Therapeutical actions, and enumerate its preparations and their doses.

3. A piece of cloth is supposed to be stained with either Sulphuric, Nitric, or Hydrochloric Acid. State how you would proceed to discover the presence of these Acids, and to discriminate between them.

4. What are the chief sources of Carbolic Acid; what is its composition; and to what class of bodies does it belong? Describe its chief Chemical properties.

Midwifery and the Diseases of Women.

1. Mention the indications for the performance of Podalic Version, and describe the operation.

2. What are the symptoms of Epithelioma of the Cervix Uteri, and the plan of treatment you would adopt?

3. What are the causes, dangers, and management of Prolapse of the Umbilical Cord occurring during Labour?

4. Describe the method of using the "Uterine Sound," and enumerate its principal applications in the treatment and diagnosis of Uterine disease.

The following gentlemen have kindly consented to receive subscriptions in aid of the Patients' Christmas Dinner :—Dr. Galabin and Mr. Pye-Smith, House-Physicians; Messrs. Morley and Jacobson, House Surgeons; Mr. Ransford, Resident Obstetric; and Mr. Wilkinson.

Messrs. L. Porter, B.A., and R. M. Simon, B.A., have recently passed their second, and Mr. E. Amphlett, B.A., his first, examination for the M.B. degree at Cambridge.

MEDICAL WARDS.

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The following cases were admitted from Dec. 4 to Dec. 10, 1873.

ADDISON.

35—Melancholia
38—Impetigo Capitis

STEPHEN

5—Subacute Rheumatism
6—Subacute Rheumatism—Mitral Bruit
16—Acute Pleurisy
18—Vomiting—Organic Disease of Stomach
23—Rheumatism?
26—Bronchitis
30—Gout
34—Albuminuria
36—Perityphlitis
44—Disease of Spinal Cord

MARY.

7—Dyspepsia
16—Anæmia
22—Erythema Nodosum

BRIGHT (PETERSHAM).

10—Cephalalgia
20—Chorea

PHILIP

28—Miasmatic Poisoning
47—Bronchitis
50—Bronchitis

JOHN (Clinical).

3—Hydrochloric Acid Poisoning
16—Epistaxis

MIRIAM (Clinical).

21—Cerebral
24—Chorea

SURGICAL WARDS.

—o—

The following cases were admitted from Dec. 4 to Dec. 10, 1873.

ACCIDENT.

21—Fracture of Tibia and Fibula

CORNELIUS.

5—Fracture of Tibia and Fibula
7—Fracture of Tibia and Fibula (Pott's)
8—Crushed Leg (Amputation)—Severe Injury to Right Knee-joint—Comminuted Fracture of Left Humerus
12—Contused Ankle
13—Fracture of Tibia and Fibula
17—Thecal Abscess of Right Hand

LYDIA

6—Disease of Knee-joint

MARTHA

15—Strumous Cervical Glands

JOB.

18—Hæmorrhoids
22—Disease of Left Tarsus

NAAMAN.

22—Disease of Carpus

LUKE

4—Peritonitis following Injury
13—Strumous Disease of Testicle (Left)
15—Double Hare-lip and Cleft Palate

LAZARUS.

3—Stricture of Urethra
13—Fistulæ (Urinary ?)

CHARITY.

2—Carcinoma Mammæ
4—Fracture of Tibia and Fibula
6—Otorrhœa
17—Inflamed Bursa Patellæ

DORCAS

No Admissions.

CORRESPONDENCE.

—o—

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents*]

THE LATE ALLEGED DISTURBANCE AT ST. THOMAS'.

To the Editor.

Sir,—A crowded meeting of students was held on Thursday, the 4th inst., in the Anatomical Theatre of St. Thomas' Hospital, to consider certain libellous statements made in certain daily journals, concerning the behaviour of the students while an inquest was being held in the Materia Medica Museum of that hospital. Mr. Fancourt Barnes was called to the chair. He began by informing the students of the object of the meeting, and said they had met to consider what steps should be taken to prevent a recurrence of such unmerited abuse; he said it was only natural that such a paper as the *Morning Advertiser*, which he wished to explain was the organ of the Licensed Victuallers' Society, or, in other words, the organ of the publicans of London —a journal, in fact, which was known as "Swipes Journal" —should seize such an opportunity of serving up the stock-dish so acceptable to the public of blackguarding medical students. "But you will be surprised to hear," he continued, "that you are indebted to your Treasurer for the abuse with which the journals have treated us; I have been credibly informed that Sir Francis Hicks was advised by a competent authority, that our Materia Medica Museum was an unfit place for an inquest, and must eventually lead to trouble; this advice was given before an inquest was ever held in the hospital, and Sir Francis Hicks neglected the timely warning, hence the result. The place the British Jury has always been accustomed to when it 'sits on bodies' is the nearest public house, and it is a more congenial place for them. They drive us out of our museum whilst in the midst of our studies to make way for the Coroner and themselves. The fact that Dr. Peacock was obliged to leave off in the middle of a lecture recently, to request the British Jury to make a little less noise. Seeing this, I beg leave to propose the following resolution":—

"That a deputation of students be chosen to wait on Sir Francis Hicks to request him to withdraw his permission to the Coroner for East Surrey, to hold inquests in our Materia Medica Museum, inasmuch as the holding of these inquests has exposed the students to unmerited insults in certain journals, and interferes in no small degree with the proper business of the Medical College." Mr. Peck rose to propose an amendment, viz.—that the deputation should in the first instance wait upon the Dean, Dr. Peacock, as representing the Medical School, instead of Sir Francis Hicks. Mr. Fancourt Barnes put the amendment to the meeting, and it being unanimously carried, the following gentlemen were elected to form a deputation to wait upon the Dean the same afternoon:—Fancourt Barnes, Esq., H. B. Donkin, Esq., M.B., B.A., Cantab., R. H. Campbell, Esq., B.A., Cantab., James Black, Esq. and F. H., Peck, Esq.

Mr. Barnes then said that he took it for granted that none of the students would make any noise, should another inquest be held in the Museum, inasmuch as he took it that such journals as the *Morning Advertiser* and the *Echo* would only be too glad to sieze on any pretext for serving up a "rechauffé" of their favourite dish "abusing medical students." A vote of thanks was given to the chairman by Walter Tyrrell, and the deputation soon after waited on Dr. Peacock, through whom their petition was forwarded to the Treasurer. He has, however, refused to withdraw his consent to Mr. Coroner Carter, so the students have passed a resolution (through the deputation) to hold him (the Treasurer) responsible for any further libels which may occur.

I remain, Sir,
Yours obediently,
Fancourt Barnes.

FOOTBALL CLUB.

—o—

GUY'S (I.) v. KING'S COLLEGE.

This match, played on our ground at Blackheath last Saturday, we won by two goals and ten touchdowns to nothing. Guy's having lost the toss, Robson kicked off and the ball being well followed up was kept down at the King's goal, and after a few scrimmages, Gray by a capital run took the ball down to their goal line where he was collared; but Welchman, who backed him well, got hold of the ball, and ran in from the try, a very difficult one; Gray, by a well-judged kick, obtained a goal. Hetley, just before half time, secured another try between the posts, from which Gray was again successful. After half time King's played up a good deal better, and kept the ball for a few minutes in the centre of the ground, but Guy's steadily drove them back to their own goal, where they were penned until time was called, having to touchdown several times in self-defence. Besides those already mentioned, Brown and Kerr played well for us. The following was the team:—Robson (captain) and Breach (backs), Gray (three quarter back), Brown and Welchman (half backs); Gibb, Gilbert, Wells, Wallis, Wilkinson, Collins, Hetley, Elliot, Kerr and Jumeaux.

GUY'S (II.) v. SOUTHGATE F.C.

This match was played at Southgate on Saturday last, and ended in Guy's obtaining two goals, two tries, and five touchdowns to three touchdowns. At first it seemed as if Southgate had the strongest team, as they compelled us to touch the ball down twice before we scored. But our men soon began to play well together, and just before half time was called Maltby ran in with the ball, and J. Carey obtained a goal by a good place kick. In the last half hour we kept the ball in our adversaries' quarters, our halfbacks playing remarkably well. Maltby obtained our second goal by a splendid place-kick. Among the forwards Gardner and Roberts distinguished themselves, while Villiers and Bain played well for Southgate. The following played for Guy's:—A. Carey (captain), Dunlop and Champion (backs), Gardner (three quarter backs, J. Carey and Smart (half backs), Mutch, E. Duke, Maltby Roberts, Perry, Mitchell, Peskett, Stevens, Levien.

MATCHES THIS DAY.

First Fifteen *v.* Blackheath F.C., at Blackheath.

Second Fifteen *v.* Merchant Tayler's School, at Victoria Park.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

ANSWERS TO CORRESPONDENTS.

One of Them—Next week.

A. W.—The plan generally adopted is to post all the paid-up subscribers on the day of publication, the others are generally sent off on the Monday; but a line to the Publisher will put the matter right.

GUY'S GLEE CLUB.

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Guy's Hospital Gazette.

VOL. III.—No. 12. SATURDAY, DECEMBER 20, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

—o—

A CASE OF COMPOUND FRACTURE OF THE TIBIA AND FIBULA, WITH REMARKS.

BY H. WILLIAMS.

(*Continued from page* 82.)

The fact of the boy having had a fractured clavicle might be taken by some as indicating a predisposition to fracture. but I think the capital power of repair which he showed would fairly negative any such idea as that, the two dispositions being incompatible.

Fractures at the junction of the middle and lower third of leg, the result of indirect violence, are, as a rule, oblique in direction, the fragments being generally bevelled at the expense of the posterior surface of the upper and the anterior of lower; occasionally just the opposite is the case. The spasmodic contraction of the muscles of the calf in the former instance causes projection and riding of the upper fragment, in the latter case, of the lower. In this instance the slight obliquity which existed was of the first kind, so the upper fragment was the protruding one. Of course no question of amputation arose in this case: the youth of the patient, the non-comminution of the fragments, the integrity of the tibials, and the absence of much laceration of soft parts and venous effusion, all favoured a good prognosis.

Now for a few words as to the way in which this fracture was "set" and put up. Firstly, as to the use of chloroform; I am sure this agent is not employed often enough in the putting up of fractures; judging from my own feelings on this point, the dresser feels reluctant to ask the House Surgeon to give chloroform when he knows that the latter has perhaps been hard at work for several hours giving it, so he tries to make his own muscles take its place, and hangs on with all is strength to the foot of the unfortunate patient, getting some one in the meantime to tightly strap it to the footpiece of the splint. How much better is it to save oneself all this exertion and the patient all this pain by having him anæsthetized. I must digress a moment to deprecate the frequent use or rather abuse of strapping; looking at it in a financial light only, it is wasteful and extravagant; owing to the wealth of Guy's, an almost unlimited amount of strapping is allowed to the dressers who consequently rely upon the tightness and abundance of their strapping for the steadiness of the limb and the opposition of the fractured ends of the bone, when, by a little attention to the padding of the splints, and the relaxation of muscular spasm, the same good end will be attained with a vast deal more comfort to the patient. It is not easy to imagine the horrible pain which is given to the patient by the struggles which go on between the spasmodically constracting muscles of the calf and the tightly fastened foot, the fight continuing until at last relief is given by the strapping giving way. The dresser comes next morning, laments the failure of his work, and re-straps tighter than ever.

I am sure the tight strapping, put on sometimes without ever protecting the foot by a little lint, has very often to answer for a sloughing heel; its object is to press the sole of the foot against the foot-piece, but its effect is to jam the heel down into the angle of the splint. It is true that at this angle there is an interruption on purpose to receive the heel, but the benefit of this is annulled by the padding of the splint being in one piece, without an interruption to correspond with that on the splint. This pad is stuffed with tow of an even thickness all along, so that when the leg is placed on it the great points of pressure are the calf and heel, while there is scarcely any on the intermediate

surface. This is obviously bad; the greatest pressure is on a point which should have none at all. Oat chaff is much better than tow for the stuffing of pads; its advantages are many, I will mention the principal; its mobility inside the pad enables one to alter the thickness of the latter to correspond with the natural curves of the limb, thus only just enough padding is wanted under the calf to protect it from the splint, while the pad should be made thicker to fill up the concavities above and below it; at the heel little or none is required, it should be allowed to fall into the interruption meant to receive it. This is very difficult to do with tow stuffing. Another advantage of oat chaff is that it never gets worked up into a hard mass like tow does, so never becomes uncomfortable. Wheat chaff is too coarse and prickly.

In fractures which I put up, I alway like to be able to put my finger in the hole of the splint and feel all round the heel so as to satisfy myself that there is no pressure upon it. If the heel be allowed to press on a pad filled with tow, the stuffing gradually gets harder and harder, and a slough of the heel, which will perhaps keep the patient in the Hospital some weeks after his fracture has united, will be the result.

For the purpose of still further equalizing the prsssure, curved back splints to suit the natural imdulations of the limb are much better than straight ones, and I think also that the back splint should be long enough to reach to the top of the propliteal space. I have seen a dresser lamenting that he could not prevent the end of the upper fragment of an oblique fracture of the tibia from projecting, and the simple reason was that he had got a very short back splint which did not reach beyond the tibia; the leg was swung, consequently the end of the splint acted as a fulcrum on which the weight of the knee and thigh tilted up the tibia.

Iron back splints are better than wooden ones for compound fractures; the fœtid discharges soak into the latter and necessitate their frequent change. In simple fractures, wooden ones are better owing to their lightness.

My slight experience in the various modes of putting up fractures has convinced me that the method adopted in this case is as a rule the best, though it is far from my wish to lay down an arbitrary rule: each case requires some modification to suit its individual requirements. I do not think, and I believe the experience of most dressers is the same, that I ever put up two fractures in exactly the same way.

With regard to the side splints, a very common fault in them is their shortness. They ought to reach just above and grasp the condyles of the femur, a golden rule being to fix the joint immediately above and below the fracture seat of.

Do not forget the interruption in the side splint at the wound; this enables dressing to be changed without disturbing the limb, and obviates any pressure on the part.

In the case I have reported the administration of chloroform failed to relax the muscular spasm sufficiently, so the tendo achillis was divided, and the protruding bone was replaced with ease and brought to the level of the lower fragment. I think the division of the tendo achillis is unjustly looked upon as a severe measure in these troublesome cases, and one not to be resorted to unless every other means of bringing the fragments into opposition have failed. The operation is easy enough, and with moderate care no harm is likely to ensue from it; the only possible danger is that of wounding the posterior tibial artery, but I can hardly see how this can happen except with the knife in the hands of a man totally ignorant of the whereabouts of the vessel. I have seen the tendon divided in three cases while I have been at Guy's, and in none of them was the patient ever aware that anything had been done to his heel. The tendon is always repaired sufficiently well for use by the time the patient is ready to leave his bed and attempt to walk again. We are told that an injured part never regains its original perfection, but I will give you an instance, showing that the tendo achillis is not much the worse for its division. A well-known cricketer three years ago, snapp ed his tendo achillis while he was turning sharp round at the wicket; it was described as going off with a report like a pistol: this last season I saw him run all the runs made while he scored 160, and he has told me that he feels no ill effects at all from it, except a little aching when the weather is cold and wet with an easterly wind. I am certain that the division of the tendo achillis in some of those awkward cases of oblique fracture of the lower third of the leg, while I may say are the *bêtes noir* of dressers, would save the patient much pain and the dresser infinite trouble, both mentally and physically.

(*To be continued.*)

PHYSICAL SOCIETY.

The sixth meeting of the present session took place on Saturday evening last, Mr. W. H. Harsant in the chair. Mr. Giblin read a paper on "The Turkish Bath: its Prophylactic and Therapeutic Properties."

In introducing the subject, he alluded to the want of knowledge shown by medical men as to the advantages or otherwise of hot-air bathing, and pointed out the antiquity of the custom from classical history and modern excavation, and its universality from the writings of travellers in all parts of the world. Briefly alluding to the introduction of the Turkish Bath into England by Mr. Urquhart, he disclaimed for it the title of panacea given to it by the hydropaths, but regarded it as a valuable therapeutic agent. He then gave a lively description of the various processes of the bath, as usually taken in England, and mentioned the effect of the heat on

the body. Some eggs which he had placed at his side in 220 deg. F. were hard baked after ten minutes; the temperature of the body during an ordinary bath was raised to 102 deg., the pulse increased to 115 per minute; the respiration was normal. Rapidly reviewing the structure of the skin, and its functions, he pointed out how important to the economy was its glandular system, gave the results of an analysis of sweat, and showed the analogy of the perspiration with the secretion of the lungs and kidneys. He then discussed the effects of the Turkish Bath on the skin, summing them up as follows :—It perfects its structure as the external covering of the body, by rendering it supple, elastic, yet firm and strong, and thoroughly cleanses it of all impurities; it establishes its eliminating function by putting it in a fit and proper condition for the discharge of refuse matter, and the product of wear and tear; and it improves its breathing capabilities by bringing into closer relation the oxygen of the atmosphere and the blood of the cutaneous capillaries, and under circumstances more suitable for the mutual interchange of gases. From this he argued that the frequent use of the bath would prevent skin affections, the diseases due to uncleanly habits, want of exercise, chill, miasmatic poisons, &c. Passing to its therapeutic use, he mentioned cases of rheumatism, gout, and ague, which it had cured, quoted Dr. Goolden, of St. Thomas' Hospital, as to its advantages in Bright's disease, eczema, scarlatina, &c., enumerated several diseases in which Dr. Tanner recommended it, and showed from statistics how useful it was in insanity. In conclusion, and without venturing to criticise the wisdom which directs its management, he expressed his surprise that so large and liberal a Hospital as Guy's should be without a Turkish Bath, which, in such an institution, would have this among many advantages—it would enable its students to go out into the world with a knowledge of the when, and where, and how it should or should not be employed, and able to answer patients' enquiries as to its advisability or otherwise.

Mr. Utting, judging from books he had consulted on the matter, found it difficult to say what the Turkish Bath would not cure. With regard to the uniform temperature of the body, he thought it was due to heat absorbed in the process of evaporation. He asked how did the Turkish Bath prevent ecchymosis, and suggested its use in purpuric diseases. He doubted its applicability for the purpose of country practitioners, and was not inclined to believe it had any effect in the case of germs absorbed by any other surface than the skin. He knew the value of the douche in mania, and of the bath in exanthemata accompanied by marked nervous symptoms.

Mr. Fry complimented Mr. Giblin on his choice of a subject, and remarked on the large number of cures ascribed to the bath. He rather objected to raising the temperature in zymotic diseases, but approved its use in morbus Brightii.

Mr. Lamb thought the bath powerful for evil as well as good, and doubted its value to those in health, or as a treatment in ichthyosis, or as an oxidiser. He conceded its use, however, in morbus Brightii and in pleuritic effusions, though it was not recommended by some who stated that the blood was thus thickened, and urea left behind in a more concentrated form.

Mr. Vinter mentioned heart disease as contraindicating its use, and described a case of death with that lesion in the hottest room. He had found it ineffectual in toothache.

Mr. Maltby was of opinion that the bath produced faintness and weakness afterwards. He thought the shampooers did not sweat, and so did not suffer the weakness.

Mr. Waterhouse allowed the general good health of shampooers, but thought that the great value of excercise was the accompanying exposure to fresh air, which of course could not be obtained in the bath. He compared the praise of the Turkish Bath with that of antimony as a diaphoretic in days gone by.

Mr. Whitworth did not think it was of universal good, and had suffered somewhat from its effects; he had seen it of use in sciatica and joint affections after rheumatism.

Mr. Green thought it was not used as a luxury because it was expensive, and was regarded as an extreme measure by those who took a daily sponge; he doubted its value in osteo-arthritis.

Mr. Richards, though expressing great admiration of Mr. Giblin's paper, did not understand how the internal parts would be affected by the Turkish Bath; and with regard to zymotic diseases, he was reminded of Mr. Bevan's recommendation to oil the bodies of such patients. He ascribed the difficulty of breathing ascribed by some to the expansion by heat of the gases contained in the blood, and doubted the cure of cases of hydrophobia by its means.

Mr. Cock doubted its value in osteo-arthritis, and its applicability in rheumatism and zymotic diseases. As a prophylactic he preferred healthy exercise in the open air, but advocated its use in Bright's disease and dropsies. He mentioned the cases of miners and engine men who were not healthy.

Mr. Maltby stated that he had lost weight during the process.

Mr. Pye-Smith thought that 5lbs. or 6lbs. might be lost by sweating, and would like to hear more of Mr. Giblin's direct experience in its therapeutical effects. He thought that the Turkish Bath might be expected to influence different men differently.

After some further remarks by Mr. Vinter, Mr. Giblin replied, and a vote of thanks proposed by Mr. Pye-Smith, and seconded by Mr. Utting, was carried unanimously.

Mr. R. Clement Lucas has recently passed the B.S. (Bachelor of Surgery) Examination, first division.

Messrs. B. N. Dalton and J. T. Ingoldsby (the latter for Logic and Moral Philosophy only), have recently passed the M.D. Examination at the University of London.

Messrs. A. Dodson and C. H. Golding Bird, who recently passed their second M.B. Examination at the London University, in the first division, have both taken honours: the former First Class (3) in Obstetric Medicine; the latter Gold Medal in Forensic Medicine, and Second Class (2) in Obstetric Medicine.

Messrs. R. H. Hughes, B.A., and D. B. Lees, B.A., have recently passed the third M.B. Cantab.

We regret that the name of Mr. R. A. Birdwood, B.A., was omitted from the list of gentlemen, in our last issue, who had passed their first M.B. Cantab.

At the recent examination for the Licentiate at the Royal College of Physicians, Messrs. Stericker, M.R.C.S., L.S.A.; Fry; Wilkins, M.R.C.S., and Paul, M.R.C.S., satisfied the Examiners, being all the candidates from Guy's for the L.R.C.P.

LECTURES ON MEDICINE.

—o—

ABSTRACT OF LECTURE ON FEVER, (OR NOTES OF LECTURE).

BY DR. WILKS.

Medical diseases may be divided into two great classes. Those which originate in the body under the influence of the ordinary circumstances surrounding us, and those which arise from specific external causes. The former are for the most part slow in their growth, or, if they occur suddenly, very often owe their origin to some predisposing condition of the patient. The latter, on the contrary, occur in all alike, irrespective of age and temperament, but have a special tendency to attack the young and healthy. Thus, children are especially prone to the exanthemata, and the natives of newly-discovered countries have ever been ready to fall a prey to the contagion introduced from the civilised world.

As I am about to commence with the specific diseases, in nearly all of which a febrile condition exists, I shall make some preliminary remarks respecting fever in general.

Fever or feverishness accompanies every local inflammation, and nearly every specific or zymotic disease; there is, therefore, no reason why any one class of diseases should be selected for the designation "fever." The word was adopted in ignorance, and probably for the following reason:—If feverishness was attendant, for example, upon pneumonia or other local inflammation, the latter was sufficiently well-marked to suggest an appropriate name for the disease; so, also, if the feverishness was accompanied by such peculiar symptoms as a pustular or red rash on the skin, these would be sufficiently striking to suggest such names as small-pox or scarlatina; but if with a similar constitutional disturbance there were no markedly distinctive symptoms present, the general feverish condition would alone have attracted attention and given a name to the disease. Thus, the residuum of febrile complaints, which afforded to our forefathers no characteristic features were designated *fever*, and under the appellation "*common continued fever*" several disorders were included. At the present time, therefore, we should endeavour to expunge the word "fever" as indicative of any particular class of disorders, especially as the disease best known by the name—"typhoid"—is wanting in many of the characteristics which are supposed more especially to attach to fever. We should have no difficulty in getting rid of the term were it not for the two adjective expressions—typhoid and relapsing—and which require the the word fever to be added to them. In the first we might substitute "enterica," but the relapsing fever is still waiting for a name.

Now, as regards fever *per se*, or feverishness. This belongs essentially to local inflammations and specific diseases, so that if you are called to a patient who has been for a day or two in a feverish state the probabilities are greatly in favour of his having either one of these conditions. If, after careful examination of the body, no local inflammation can be found, then you must think of a specific disease and endeavour to determine its nature by the history of the illness and the presence of characteristic symptoms, such as rashes, &c. If there be none present, the disease is usually called typhoid, because this is a disease in which the the characteristics are frequently wanting It is for this reason that so many local complaints being overlooked are designated by the name typhoid fever. I will now ask you to add to the category of local inflammation the case of tuberculosis, in which feverishness or pyrexia also occurs, and also to add to the second category of specific blood diseases the case of pyæmia or septicæmia.

When I say that the feverish state implies in nearly every case one or other of the above-named conditions, it must be remembered that in certain lesions of the nervous system the temperature will be considerably raised, but I could not maintain that this increment of heat is equivalent to fever.

The feverish state or pyrexia is marked by preternatural heat, quickened pulse, hurried respiration, furred tongue, usually dryness of skin, loss of appetite, pain in the head and limbs, dark-coloured urine, and indisposition to any mental or bodily exertion. Some of these symptoms may be absent, but the feeling of tiredness or irksomeness never. The most important or constant element in pyrexia is increase of heat; but it is not absolutely a sign of fever, for, as just now said, it may occur under various lesions of the nervous system, and on the other hand we sometimes find in the course of a local inflammation where the other symptoms of pyrexia remain, that the temperature has been reduced to the normal standard.

The temperature of the body is 98·4 deg. Fahrenheit, as we find it in the axilla. In the mouth or rectum it is higher, and in the inside of the body it is 100 deg. or more. This precise and uniform temperature in the human body is a very striking fact, it seems as if the integrity of the frame depended upon it, and that any departure is attended by some morbid condition or ill-health. The human body is a wonderful machine or furnace, perpetually burning, maintains itself at a temperature of 30 or 40 deg. above that of surrounding inert objects. This production of heat is generally agreed to be mainly due to a chemical process, and about which you have heard all particulars in the Physiological Lectures. Not only is there combustion going on in the lungs, as formerly thought, but analogous changes in all the tissues of the body; in every gland heat is evolved and most of all in the muscles. If too much heat is produced it is given off by the skin; if the loss should be too great we cover ourselves with clothes so as to retain it. It is therefore evident that man could not live in a state of nature in some favoured regions of the globe. The heat is regulated by natural and artificial means, and the standard is the balance struck between heat produced and heat lost.

You might be reminded of Sir B. Brodie's experiments of decapitating an animal and keeping up artificial respiration, followed by a lowering of the temperature, which led him to believe that the nervous system was essentially active in the production of heat, and that the chemical process would not alone account for the amount. I mention this because it is known that the temperature is often raised in nervous disorders, but whether it be due to the influence of the nerves over the blood vessels, and so nutrition, or whether in a more direct manner nerve force is converted into heat is a *questio vexata*.

It is no business of mine to enter upon the physiological question, and I only do so because it is necessary for the true elucidation of "fever." Does fever imply an excess of those processes which are constantly going forward in health? The question includes the generally received opinion, and if true my task is comparatively easy. I have merely to demand of you a recollection of what you have been taught elsewhere, and apply it to the subject under review. You have to think of the causes in operation for the production of animal heat, and then of those acting in an excessive degree, and you have fever. Although there

are good reasons for this conclusion, yet it is not entirely free from objection, for if a person takes violent exercise, and his temperature is raised, respiration more hurried, pulse more rapid, more solid matter in urine, and, in popular language, is "all in a fever," nevertheless the tongue is not furred, nor is there anorexia as in true fever. It may be that the latter symptoms would be induced did the temperature keep high for any length of time, but of this there is no proof. It has been thought that fever may be due, not so much to increased production of heat as to a diminished loss from the skin; but in answer to this I may say that the result of experimental enquiry shows that more heat is given off in fever, and with a corresponding tissue change throughout the body. I might also allude to other theories, such as that propounded by Dr. Maclaghan, at the last meeting of the British Medical Association—that there is a chemical change in the fever state, but in the case of the specific diseases this is due to the "poison germs" or "contagion" acting, not on the made tissue of the body, but on the circulating albumen derived from the food; there is, therefore, an increased combustion process, whilst the body is starved of its proper nutriment.

It is very interesting to compare the chemical change and heat product with those of health, for we thus gain a notion of the amount of wear and tear which is going on during a severe illness of the fever kind.

Professor Houghton has calculated, that if you look at a man lying on his bed—the subject of typhus fever—you have the counterpart of a traveller who has been performing a fifty mile journey in 24 hours as regards the amount of heat produced and tissue, change which has taken place in both of them during that period. You may also make a calculation of this kind: Say a man, weighing 150lbs., has walked up Mont Blanc, a height of 15,000ft., which is the same thing as that weight having been carried up. Now, if you refer to your syllabus of the Natural Philosophy Lectures you will see the meaning of the unit of mechanical work and the unit of heat; also that the mechanical equivalent of heat is 772 foot-pounds, that is, that a force required to raise a body one degree of heat would lift it 772ft. Now, if you divide 15,000 by 772 you get nearly 20, so that the force required to take a man up Mont Blanc would raise his temperature 20 deg. Suppose, therefore, that we had a patient whose temperature was raised in a short time to 10 deg., the same amount of force would have been expended as if he had walked half way up Mont Blanc. The amount of chemical change due to combustion could be reckoned from this, and the amount of fuel required for the process. In this way calculations may be made of the greatest scientific interest and value.

(To be continued.)

MEDICAL WARDS.

—o—

The following cases were admitted from Dec. 11 to Dec. 16, 1873.

JOHN (Clinical).

3—Internal Strangulation of Intestine
7—Albuminuria—Bronchitis
8—Pyrexia
9—Enteric Fever
10—Laryngeal Catarrh

MIRIAM (Clinical).

No Admissions.

PHILIP

2—Morbus Cordis—Aortic and Mitral
3—Acute Rheumatism
13—Locomotor Ataxy
16—Acute Pleurisy, with Effusion
17—Tumour of Left Kidney
34—Acute Rheumatism—Morbus Cordis—Pericarditis

STEPHEN

2—Cystitis
10—Hydrocephalus
17—Syphilis—Albuminuria
20—Morbus Cordis—Mitral—Bronchitis
29—Sciatica
31—Bright's Disease
46—Bronchitis with Emphysema
50—Gout

MARY.

7—Dyspepsia—Pleurisy

ADDISON.

7—Albuminuria (Small Kidney)—Bronchitis
10—Incipient Phthisis
26—Tonsillitis
39—Acute Rheumatism

BRIGHT (PETERSHAM).

10—Carcinoma of Liver
11—Lead Paralysis
13—Chorea
17—Disease of Hip-joint
18—Hydatid of Liver
19—Albuminuria—Ascites
22—Mitral Regurgitation—Pericardial Effusion

SURGICAL WARDS.

—o—

The following cases were admitted from Dec. 11 to Dec. 16, 1873.

ACCIDENT.

7—Dislocation of Tibia
10—Fractured Tibia
11—Injury to Knee
21—Fractured Tibia and Fibula
22—Wound of Arm
23—Fractured Femur
25—Laceration of Knee
31—Fractured Ribs—Emphysema

CORNELIUS.

1—Effusion into Knee-joint
14—Injury to Back

LUKE

No Admissions.

MARTHA

No Admissions.

LYDIA

2—Scalp Wound
3—Fracture of both Bones of Leg
7—Abscess about Jaw
8—Cleft Palate
9—Follicular Abscess of Face
16—Hæmorrhoids
17—Hysterical Knee and Talipes Varus
20—Synovitis
21—Adenoid of Breast
24—Abscess about the Rectum

DORCAS

8—Ulcerated Foot
14—Contraction of Knee-joint
16—Strangulated Left Femoral Hernia—Operation

NAAMAN.

8—Cancer of Tongue
16—Fistula

LAZARUS.

1—Hydrocele

CHARITY.

3—Injury to Elbow

JOB.

3—Glandular Enlargement in the Right Groin

TRUTH AND NEGATIVISM.

A golden thread has run throughout the history of the world, consecutive and continuous, the work of the best men in successive ages. From point to point it still runs, and when near you feel it as the clear and bright and searchingly irresistible light which *Truth* throws forth when great minds conceive it. Truth not of "Fact" merely, but Truth that includes the world that your senses are too coarse for.

This is Spenser's Arthur, with his shield. Oftentimes this noble Arthur has come to the Red Cross Knight Christianity, and delivered him from a loathsome bondage of brutal coarseness aud passion, and then gone away. And this Arthur has served other things beside religion so also; but he stays not with any religion, or any *Thing* else. Some men have always to share on the earth a part of the work Prince Arthur did in Fairy Land. The impatience of Youth in the Red Cross Knight won't wait to see the purity of Una in true religion in its social shape, or fails perhaps to see the purity of some other agency through the social forms that encumber it, say impatiently fails to see the purity of the Medical Art; and he wanders off in the power of some false and sensual pretence. But Arthur, when the strength of wandering youth is cast utterly prostate under the giant heap of faults, which are sure to follow being socially wrong, delivers him.

Arthur is the power of living truth where facts are dead. Truth that cannot see whether the false is false because the false never stands in his sight. He knows not the false, it burns away before him and is gone. But, I forgot, some people don't distinguish between *things* and *truths Perhaps you don't see that the constructive faculty of man has to make human truths out of brute things.* You don't think so! Ah! I see, you don't apprehend truths that aren't things. You think there is no devil. You don't believe in the devil, do you? But look. There is no part of your life so really real as that in which the devil is a reality. These things we touch with our fingers are phantoms beside the devil's reality. They come and go, and you can pass away from and leave them. But the devil ("Der geist der stets verneint," the spirit which loves denial) you have always near you.

Learn to fight him, and you will see how real he is, and what strength there is in victory over him.

PILOCEREUS SENILIS.

FOOTBALL CLUB.

—o—

GUY'S (I.) v. BLACKHEATH.

This match was played at Blackheath, last Saturday, resulting in a victory for Blackheath, by a goal, a try and a touch in goal to nothing. At first we played one man short, and after some sharp play, were obliged to touchdown in self-defence; on our missing man turning up the game was more even, the half backs of both sides having plenty of work, but toward half-time, the ball was steadily worked into our quarters, when after some most exciting scrimmages Blackheath obtained a try, the spectators who insisted on crowding round, being greatly in our way, and effectually preventing our backs, from even seeing the ball. From this try, an extremely difficult one, it being close upon touch, Slade by a beautiful kick obtained a goal; after this reverse Guy's played up with a will and took the ball well down to the centre of the ground. After half-time the game still continued to be most exciting, our representatives behind the scrimmages doing good service, but towards the end of the game we again lost ground, our opponents adopting throughout the game, a nasty trick of heeling the ball out of the scrimmages, from which, several men, well-competent to judge, attribute in great measure, our defeat. Just before time Blackheath obtained another try, from a scrimmage close upon our line, the crowd being just as affectionate, as at the other goal, but no goal resulted from this. Thus ended a very pleasant match, in which the following played:—Captain—Robson; backs—Breach and Pearson; three-quarter back—Gray; half backs—Finch and Brown; Gibb, Gilbert, Wells, Hetley, Welchman, Wallis, H. Duke, Kerr and Collins.

MATCH THIS DAY.

First Fifteen *v.* Richmond, at Richmond.

THE CAUSE OF THE COAGULATION OF ALBUMEN.—According to some experiments of MM. E. Mathieu and V. Urbain submitted to the Academy of Sciences, Paris, albumen, deprived of its gas is incoagulable even at 100 dgs. C., but it is precipitated by alcohol, acids, and metallic salts like normal albumen. The restoration to transformed albumen of its oxygen and nitrogen will not restore to it its coagubility; but it recovers this property on the restitution of the carbonic acid gas which it has lost. Carbonic acid gas is therefore asserted to be the cause of the coagulation of albumen underheat.—*Medical Press.*

We have been forced to postpone the continuation of Dr. Wilks' Clinical Lecture until next week.

PHARMACY.—We have received from Mr. A. W. Gerrard, at present dispenser and teacher of Pharmacy at University College Hospital, but formerly at this Hospital, a new preparation that has long been required, a preparation of phosphorus that can be taken pure and without inconvenience to the patient. It consists of a 4 p.c. solution of phosphorus in heated resin, which is made into pills with white sugar and Tincture of Tolu. The "Phosphoretted Resin" has a decidedly disagreeable odour of phosphorus, but the pills are almost free from this, which has been perhaps the greatest difficulty in the preparation of phosphorous compounds, and that without any of the usual coating. The plan has been to dissolve the phosphorus in some volatile substance, such as bi-sulphide of carbon, ether, oils, &c.; but the disgusting odour of such compounds was a complete bar to their general use, and the therapeutics of phosphorus still remain to be discovered. Those, who would add to the little knowledge we possess of the action of this drug, will do well to take advantage of the opportunity offered, for the first time, by Mr. Gerrard's elegant preparation—the Pills of Phosphoretted Resin.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Country.

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And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

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Guy's Hospital Gazette.

VOL. III.—NO. 13. SATURDAY, DECEMBER 27, 1873. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

ORIGINAL COMMUNICATIONS.

—o—

A CASE OF COMPOUND FRACTURE OF THE TIBIA AND FIBULA, WITH REMARKS,

BY H. WILLIAMS.

(*Concluded from page* 90).

Why was not this fracture treated antiseptically? Because we have had very little experience at Guy's as to the benefits of the antiseptic method in compound fractures. The assistant-surgeons, who are the great advocates of this dressing, very rarely get these cases under their care. The use of the carbolic oil in this fracture must not be looked upon as one of those amusing instances of semi-antiseptic treatment, in which the adopter seems to have undergone a half conversion to this method. Carbolic oil, apart from any antiseptic value, is a capital dressing for fresh wounds: its virtues belong more to the linseed or olive oil it contains than to the carbolic acid. The former acts as an emollient, relieving pain, and encouraging the free exudation of lymph from the lacerated tissues, while the carbolic acid is used more as a deodoriser than anything else. Let this oil be lightly applied on lint, and the dressing moistened whenever it shows signs of getting dry.

One of the advantages of swinging fractures is that the position is easy to the patient; but the swinging of this youth's leg gave him intense pain, which was relieved directly the limb was let down on to the bed. I think this is a minor point worth mentioning.

Notice the mild attack of traumatic fever which came on 24 hours after the injury, and lasted four days. His maximum temperature was 102·5, with his pulse 116, 48 hours after admission, then it gradually subsided There is never any cause for alarm in the onset of pyrexia; in fact, its absence would be looked upon as rather a bad sign, showing a want of reactionary power. A surgeon—I think Mr. Le Gros Clarke—says that in healthy patients the pyrexia following accidental or operation wounds, is, as a rule, in direct pr oportion to the amount of previous shock the greater the shock and collapse, the greater the subsequent reaction. He illustrates it by comparing the normal human condition to a tall straight reed, which, if bent one way by the wind, will, when the gust has passed over it, return with sufficient force to become bent in an exactly opposite direction. This early pyrexia has nothing at all to do with the occurrence of suppuration; it will often have disappeared before the rigors, which are our surest and earliest indications of impending pus-formation, come on. In this case the pyrexia had gone before the sloughing of the tissues began, and there was a remarkable absence of any constitutional disturbance while this process was going on.

Carbolic acid lotion (1-20) was now used instead of the oil, as being more stimulating, and so aiding the separation of the sloughs. Again, the dressing was simply laid on the part, without any confining bandage, and changed twice a day. I will take this opportunity to deprecate the use of tight dressing to the wounds of compound fractures: let everything be loose and frequently changed, especially at this sloughing stage; a lot of dressing confines the discharge which will make its way somewhere, and if it cannot get out of the leg, it will burrow up and down the limb, and at last convert the whole member into one large abscess.

There was a little tendency to suppuration at one point to the outer side of the wound, but an early incision prevented it coming to anything.

The next point of interest is the wiring together of the bones, which was suggested by Mr. Birkett, and done by Mr. Turner, the House-surgeon. I had never seen nor

heard of it before; it is a first rate contrivance for keeping the fragments steady, and in good position. There is no difficulty in getting the wire away after union has taken place, as might be supposed, because the bones must be bare to enable them to be wired, and the ligature will probably come away with the necrosed portion after it has served its purpose, as it did in this case.

On March 9th, he got an attack of erysipelas, not merely lymphatic inflammation, but the real specific disease, for there was a diffuse scarlet patch on his thigh, he had a thickly furred tongue, with anorexia and constipation, but without nausea. It being a case for active treatment, I gave him 20 grs. of Pulv. Emeticus with orders to repeat it if it did not act, as well as 2 oz. of Mist. M. cum M.S. He vomited twice after the emetic, and the next day the blush had gone, his bowels had been freely open, his tongue was much cleaner, so he was ordered the Iron and Quassia. In spite of the short time this patient had erysipelas, he managed to infect two of his neighbours with it. The effect of the emetic in cutting short this attack at its onset was very striking. I think it is only fair to give the medicine the credit of it, though perhaps it might only have been a very slight attack which ran its course, instead of the begining of a severe one. I verified the good effect of a prompt emetic in two or three cases after this, in fact, though several of my patients began with erysipelas, yet, thanks to the emetic, not one became bad enough to be sent to Samaritan Ward. A good dose of Tartar Emetic and Pulv. Ipecac. will rarely fail in stopping the distressing sickness which ushers in the attack, and it will bring down both the pulse and the temperature: let its action be assisted by a good dose of white mixture. Do not give the large dose of iron until the tongue has become clean if it is given, it is not absorbed, and only causes further stomach distress.

In conclusion, I will write a few words on the most important point of the mode of repair of compound fractures, and the way it was exemplified in this case. Compound fractures, followed by sloughing of the soft parts and necrosis of the whole thickness of one of the fragments to a limited extent, are repaired by the process of granulation. In the case I have recorded, the whole thickness of thebone did not perish, but the stripping off of the periosteum from the surface caused death of the layer of bone subjacent to it and nourished by it. The dead bone is cast off, and the loss repaired, by a crop of granulations springing up on the surface of the living bone, which ultimately becomes converted into new bone. This process could be beautifully seen in this youth's leg. After the bones had been wired together about a fortnight, I noticed a minute granulation protruding through the wire-hole on the anterior surface of the the upper fragment; it had forced its way by the side of the wire. This florid granulation was a good indication of what was going on underneath the dead shell of bone, and in a few more days the said shell became loose, and was removed, exposing a level surface of very vascular granulations. The upper fragment came away thirty-five days after it had lost its periosteum, the lower one was eleven days after it. Nothing was now to be seen but a healthy granulating wound, on which I grafted some skin with benefit.

It is a somewhat disputed question how the granulation tissue becomes converted into bone. Some affirm that it must first be made into connective tissue, the corpuscles of which become ossific centres: others maintain that osseous granules are deposited primarily in granulation tissue and that there is no intermediate fibro-connective stage; in support of this idea is a preparation in the Museum of the College of Surgeons, which represents primary osseous deposit in a bunch of granulations which have protruded from the medullary canal of a femur after amputation.

CORRESPONDENCE.

—o—

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents*]

RUPTURED TENDO ACHILLIS.

To the Editor.

Sir,—As an old Guy's man, and a constant reader of the *Guy's Hospital Gazette*, I must take the opportunity of expressing the great pleasure it gives me to read from week to week articles, letters, reports of cases, &c., published in your excellent paper by students, and written in a manner which would do credit even to their teachers. As an instance I may allude to the remarks upon a case of compound fracture now being made by Mr. H. Williams. (If this gentleman is the same whose name appears frequently in the *Gazette*, and who made the splendid diagnosis in the Clinical Ward, which was alluded to by Dr. Wilks at his lecture, I should say he must be a rising man, and one of whom the "old school" may justly be proud.)

That portion of the paper to which I wish to allude is the one which relates to the lesion of the "tendo achillis." I entirely agree with him as to the advantages of division of that tendon in bad fractures of the tibia and fibula, and feel sure that if it were done more frequently we should not see the bad results which we constantly do in hospital practice. The operation is a very trivial one, and when once done it saves that constant taking down and re-puttiug up of fractures, which we are obliged to resort to in order to remedy the antagonistic action of the muscles of the limb. "So far so good," but when Mr. W. goes on to infer, if not

actually to say, that the spontaneous rupture of that tendon by muscular action is a somewhat common occurrence, I cannot help thinking he has allowed his enthusiasm on the subject to get the better of him. I do not recollect seeing a case during my four years at Guy's, and certainly I have never met with one since, although I have seen a very large proportion of surgical cases during that time; in addition to this I believe all surgical authors describe the accident as an exceedingly rare one. In support of his statement I notice that Mr. Williams alludes to the case of a well-known batsman, who was the subject of this accident some three years ago, andwho has evidently afforded Mr. Williams the greatest delight by his performances at the wicket. All I can say is, "long may they both live," the cricketer to perform for Mr. Williams' amusement, but I am not speaking without "my book" when I state the tendon ruptured on the occasion alluded to was not that which Mr. Williams is so sweet upon—it was the "Plantaris."

TENOTOMY.

Mr. Robert C. Richards writes, in reference to our last report of the Physical Society, that—

"He did not attribute the difficulty of breathing experienced by some in the Turkish Bath to the expansion of the gases contained in the blood, but to the expansion by heat of the atmosphere of the room and the consequent diminution of the supply of oxygen."

"He said nothing about oiling the bodies of fever patients, but contrasted the plan of oiling the bodies of medical practitioners in order to prevent the absorption of zymotic poisons, with Mr. Giblin's recommendation to use the Turkish Bath as a means of attaining the same end. The two methods seemed to him diametrically opposed."

APOTHECARIES' HALL.

At a recent examination Mr, H. M, Powell was admitted as a Licentiate.

The following were the Questions set :—

1. Describe a case of Cirrhosis of the Liver, the P.M. appearances, and the treatment in the early and late stages.

2. Describe a case of Diabetes, and state what complications might arise.

3. What are the causes of Intestinal Obstruction? State your reasons for thinking so, and give treatment.

4. Describe the different kinds of Pneumonia.

5. Trace the difference between Laryngitis and Laryngismus Stridulus.

6. How would you distinguish between the coma of Alcohol, Opium, and Uræmic Poisoning. Give treatment.

7. What are P.M. differences between a case of death from Asphyxia and also from Syncope.

8. Describe a case of Arsenical Poisoning. Give the tests for discovering Arsenic in the body.

9. Describe a Breech and Arm Presentation, and give treatment from commencement of the labour to the finish.

10. Describe a case of Puerperal Peritonitis, and give treatment.

11. What are tests for Strychnia, Cyanide of Potassium.

12. What do you mean by the Strumous Diathesis, and what are the diseases associated with Tubercle.

13. What are the consequences of a precipitate labour?

Clinical.

Hypertrophy of Heart, and pushed 2in. to the outer side of middle line of Sternum. Old Pleurisy.

Give the therapeutical uses, doses, and preparations of Iron, Quinine and Arsenic.

(From the *Medical Press.*)

THE EFFECTS OF TOBACCO SMOKE.—M. Gustave Lemon, of Paris, has recently issued a treatise upon the Chemical and Pathological Effects of Tobacco Smoke upon the Human System, the author having first constructed a variety of apparatus, by which he has been enabled, he states, to collect and show with exactness the various elements of smoke which condense and deposit themselves on the organs of the smoker. One hundred grammes—1,300 gos., English troy—of French tobacco furnish 0.550 grs. of nicotine and 0.499 grs. of ammonia. Tobaccos of the Levant are the least daagerous, some of them possessing but a small trace of nicotine. In small doses, he says, tobacco smoke instantaneously excites cerebral activity and the intellectual forces, and facilitates digestion. In excessive and frequent doses, it produces difficulty of digestion, benumbed intelligence, and clouded memory.

BLOODLESS SURGERY—THE ELASTIC LIGATURE.—We understand that on Thursday last a case was operated on by Mr. Stokes in the Richmond Hospital by the method recently recommended by Prof. Dittel, of Vienna. The case was one of complete fistula in ano, the internal orifice of which was situated very high up. The elastic ligature was passed through the fistula and fastened in the manner recommended by Prof. Dittel. The patient suffered a good deal of pain during, and for about an hour subsequent to, the operation.

FRACTURE OF THE CLAVICLE TREATED BY PLACING THE ARM BEHIND THE BACK.—M. Broca recently treated a case of fracture of the left clavicle, in which the fracture was near the middle of the bone; was oblique, from above downwards and from without inwards, the fragments riding one another considerably. After numerous plans of treatment had failed to reduce the fragments, M. Broca adopted a suggestion made last year by Dr. Michel to the Societe de Chir., and which is reported in the *Jour. de Med. et Chir. Prat.* He placed the arm in a semiflexed position behind the back, where it was retained by a bandage for eighteen days, with the effect of completely adjusting the fractured surfaces and producing an excellent cure. For a few days longer a sling was used. The patient, a man of considerable nerve, complained of the inconvenience and pain of the method for only the first twenty-four hours.

We have been forced to postpone the continuation of Dr. Wilks' Clinical Lecture until next week.

LECTURES ON MEDICINE.

—o—

ABSTRACT OF LECTURE ON FEVER.

BY DR. WILKS.

(*Continued from page* 93.)

You may ask whether the increment of heat in fever has been proved to be proportionate to tissue change by the increased amount of excreta voided by the body? This has not been accurately ascertained, as the investigation is a difficult one, for it would be necessary to analyse the secretions from the intestine and from the surface of the body, as well as the urine, and the expired air from the lungs. As regards the urine, observers differ, but it is generally admitted that the solids are increased; the urea, uric acid, phosphates and sulphates, but not the chlorides which are deficient in febrile complaints. The increased amount of carbonic acid given off by the lung is 2½ times more than in health, and therefore this alone would go far to account for the increased tissue change and corresponding increment of heat.

No fact connected with the use of the thermometer has been of more interest, or perhaps of more practical value than that which associates a necessary stoppage of vital action with a great departure from the normal standard of heat. Thus, the normal temperature being a little more than 98 deg. F., fever heat has an average of 104 deg., and there is good reason for the belief that this excessive heat to which the animal body is raised is productive of many of the symptoms and ill consequences which are observed in the febrile state. We are no longer satisfied with regarding this state as a necessary accompaniment of a local inflammation or specific disease which must run its course, but that the high temperature may be fruitful of further danger, and should, therefore, be especially attacked by refrigerent means. A temperature of 109 or 110 is incompatible with life, and thus we have at last found a clue to the cause of death in sunstroke, and in some remarkable disorders. The former, which is more properly called heat-stroke, may occur in a hot climate in the night as well as the day, and is due to the sudden rising of the temperature of the body from the external heat and inability to throw off the retained heat from some peculiar state of the atmosphere. If the temperature of the body rise 10 or 12 degrees above normal, the blood and muscles undergo a change and life must cease. In one of the late summers a lad wheeling a barrow down Fleet Street was taken suddenly ill and carried to Bartholomew's Hospital, where he died in an hour. His temperature was found to be 110. It was not until lately that we were able to explain the phenomena attending a very fatal form of rheumatic fever. There had long been known a complication styled metastasis to the brain in which the arthritic inflammation subsiding the patient became delirious and quickly died, the post-mortem examination showing no visceral change to account for death. We now find that at the onset of these symptoms the temperature quickly rises until it may reach 108 or 109, and in a short time the patient dies. This condition is called one of hyperpyrexia. With this important fact the appropriate treatment is obvious—to reduce the heat by any possible and speedy method. The house is burning, and the fire must be extinguished. The patient must be put into a cold bath again and again until the heat is reduced, and the immediate danger has passed. The plan has been adopted in many cases, and with the most successful results. In the same manner the cold bath is being used in typhoid and other febrile states when the temperature rises to a dangerous height. It is said that throughout many parts of Germany the mortality in typhoid fever has been much reduced since the adoption of the cold-water treatment.

Whether, when death has occurred, combustion can still go on until the body is consumed, I do not know. Some writers have spoken most positively as to undoubted cases, whilst the profession generally remains incredulous. Some years ago a controversy took place between Mr. Dickens and the newspaper press on the subject of spontaneous combustion, in consequence of the author stating that when Mr. Krooks' room was entered nothing was found in his chair but a little grease and a cinder.

What is the lowest temperature which can support life I cannot tell you, but that all vital action is suspended when the heat of the body is much lowered is a self evident proposition. If this is so, it is no doubt true that all departures below the natural standard are injurious to the normal processes of nutrition which are constantly going on in the body. Sufficient attention has not been paid to the subject, but at present I will merely draw your attention to the fact that all the wonderful processes which are constantly in operation in the interior of our system require a temperature of 100 deg., and that the fœtus was developed during the nine months it was inside its mother's womb at the same temperature. I will also draw your attention to the opposite fact of a low temperature being instrumental in arresting every stage of development and growth, as is seen in the fact of the possibility of carrying the ova of fish to the Antipodes if preserved in a cold chest. A practical lesson to be drawn would be by asking you to consider well these facts when you have to treat wounds on the surface of the body. It is no business of mine to advise you as to your proceedure after surgical operations, but I cannot be doing wrong when I say that for the healing of a wound a certain degree of heat is required, and that if this be equal to the normal heat of the body, the nutritive processes will proceed the more readily. I need not say what my reflections are on this subject when I hear so much of the cleaning of wounds to get rid of putrid secretions and imaginary poisonous germs, and for this purpose hear of the stump of an amputated leg being exposed to a constant stream of cold water by which its temperature is reduced to 50 or 60 deg., and when I at the same time know how when, for example, all the fingers of the hand are crushed and immediately bandaged up, perhaps in a clumsy manner, in a few days the severed parts will grow together again with an extraordinary rapidity. Healing by the scabbing process is also very rapid, both in man and the lower animals. Think, therefore, again of health and healthy processes in connection with a remarkablyfixed temperatnre. We are indebted mainly to Wunderlich for teaching us the importance of the rise and variations of temperature in the human body as indicative of unhealthy states. He has endeavoured to show that in disorders attended by febrile disturbance the rise of the temperature will at once point to its approach, and according as this rise is sudden or slow, so may the various forms of specific and local disease be anticipated. It is no doubt true that the rise varies in different disorders, and could I thoroughly rely upon the statements of Wunderlich, I would compare his tables of temperature so as to enable you to gain at a glance an idea of their differences for the purposes of diagnosis. Later observations, however, have shown that these are not altogether reliable, and therefore until we have arrived at more accurate conclusions I think I had better not endeavour to lay down any rules

respecting the progress and decrease of fever in these complaints. I shall wait until I treat individual diseases, and then tell you what we positively know from observations of our own in respect to this subject.

When we make a table of temperature we speak of the increment of heat as the "rise" and the fall as the "defervescence"; when the latter is sudden it has been styled the "crisis" and if gradual the "lysis." It has been said that with each degree of heat, the pulse rises 10 beats. This is not absolutely true, but a proportion of the kind does exist. For example, with a temperature of 98 pulse of 60, with a temperature of 99 there would be a pulse of 70, and with a temperature of 104 deg. a pulse of 120.

(*To be continued.*)

GLEE CLUB.

The members of the Guy's Hospital Glee Club gave their annual concert in the Court Room, on the 19th inst., before a crowded audience, who seemed very enthusiastic in their approval of the several pieces.

The first part of the programme opened with a glee, entitled "The Red Wine Flows," sung without an accompaniment, in which the voices blended well, and so was rendered with great spirit. Mr. Wright was the first to put in an appearance as a soloist, by singing "She Wore a Wreath of Roses," and, on this being re-demanded, he sang "Good-bye, Sweetheart." Next followed the "Erl King," (a very pretty arrangement of the old legend by Callcott), in which Messrs. Sangster and Poland supported the solos, the former gentleman being especially heard to advantage in "the plaintive voice of the child speaking to the father"; now came a violin solo by Mr. Bell, the subject being a fantasia on the principal airs in *Somnambula*. Seldom have we heard an amateur who plays in such exquisite style, and he appears to be a perfect master of his instrument. We must congratulate the Glee Club in having as one of its members so talented a porformer. We would now notice the old glee, "The Bells of St. Michael's Tower," given with much precision, the forte and piano passages receiving every respect due to them: this glee gained an *encore*. "Terence's Farewell," by Mr. Sangster, was a great success, after which he treated the audience with "Drink to me only with thine Eyes." The first part of the programme was brought to a close by that pretty trio, "The May Fly,' by Messrs. Nash, Rudd, and Sangster, which we think was one of the best things of the evening.

After the usual interval, we were glad to have an opportunity of hearing one of Bishop's glees, without which a programme of this kind would not have been complete. Hatton's "King Christmas" was now given by Mr. Nash (who was in good voice), and it was exceedingly well rendered, he substituting as an encore "Simon, the Cellarer." Mazzinghi's "Wreath," which is such a general favourite, was nicely sung by Messrs. Baker, Pye-Smith, and Wright; and then we again had the pleasure of listening to Mr. Bell, who this time chose a selection from *Martha*. If we may draw a comparison, this seemed even more effective than his former piece, he being most rapturously encored. The simple, but pretty, round, "The Poet's Tomb," was well sustained; and then followed the only duett of the evening, by Messrs. Nash and Sangster, the time being excellent throughout. In the glee which followed, although pleasing, it was surely taken too fast. Mendelssohn's open-air quartett and chorus, "The Summer Song," was not so successful as the rest of the glees, perhaps to be explained by the fact that the men were fagged by their long programme and yet this could not have been the sole reason, as the last chorus, "Hearts of Oak" was sung with great energy. After respecting the time-honoured custom of singing the National Anthem, a vote of thanks was accorded to those who had taken part in the concert by Mr. Gurney Hoare, the compliment being acknowledged in suitable terms by Mr. Nash.

Before closing this report, we cannot refrain from admiring the excellent manner in which Mr. Smith discharged the duties of accompanyist; and we must also congratulate Mr. Nash, who was a most efficient conductor on the occasion, on the success of the entertainment; and we hope that there will be a good balance to hand over to so noble a charity as the Guy's Samaritan Fund.

MEDICAL WARDS.

The following cases were admitted from Dec. 17 to Dec. 23, 1873.

JOHN (Clinical).

16—Epilepsy

MIRIAM (Clinical).

23—Acute Rhenmatism—Albuminuria

PHILIP

11—Hæmoptysis
13—Morbus Cordis—Aortic
33—Bronchitis
32—Subacute Rheumatism
43—Acute Rheumatism

STEPHEN

16—Acute Rheumatism
17—Syphilis—Albuminuria
20—Bronchitis—Mitral Bruit
31—Bright's Disease

MARY.

12—Cystitis

ADDISON.

8—Morbus Cordis—Mitral—Albuminuria
15—Ascites

BRIGHT (PETERSHAM).

9—Subacute Rheumatism
18—Subacute Rheumatism
22—Regurgitant Mitral—Pericardial Effusion—Pleurisy

SURGICAL WARDS.

—o—

The following cases were admitted from Dec. 18 to Dec. 23, 1873.

ACCIDENT.

2—Dislocation of Femur
5—Compound Fracture of Right Tibia and Fibula—Simple Fracture of Left Tibia and Fibula
8—Dislocation of Femur
13—Scalp Wounds—Lacerated Superior Tarsal Cartilage
23—Fracture of Fibula

CORNELIUS.

1—Injury to Knee
9—Fracture of Tibia and Fibula
11—Fracture of Tibia and Fibula
12—Sprain of Ankle
14—Wound of Elbow and Contusion
16—Fracture of Tibia and Fibula
18—Fractured Patella
20—Fracture of Tibia and Fibula

LUKE

No Admissions.

MARTHA

19—Abscess of Mamma
22—Syphilitic Ulcer of Lower Lip
22—Concussion of Brain

NAAMAN.

7—Dislocation of Femur
8—Epithelioma of Tongue—Operation
9—Strangulated Femoral Hernia reduced under Taxis

LAZARUS.

3—Necrosis of Metatarsal Bonas

LYDIA

No Admissions.

JOB.

No Admissions,

DORCAS

13—Scalp Wound
23—Specific Ulcer of Thigh

CHARITY.

14—Ulcers of Leg
15—Severe Injury to Brain—Death
16—Necrosis of Tibia

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

NEW INVENTIONS.

—o—

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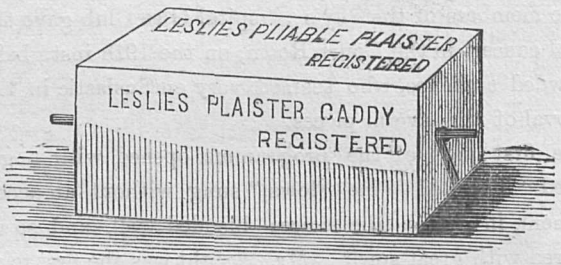

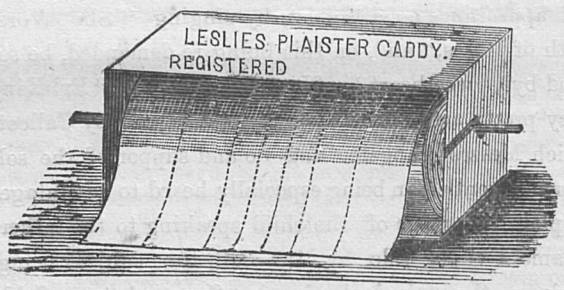

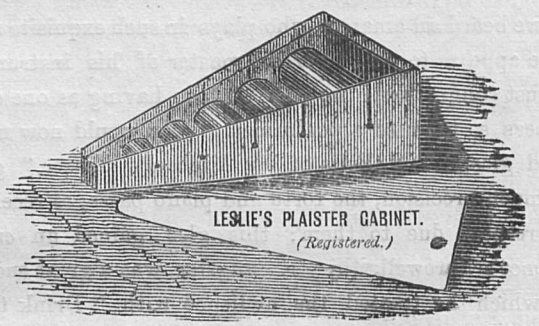

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GUY'S v. RICHMOND.

This match, played at the Old Deer Park, Richmond, after a most exciting and evenly contested game, was won by Richmond by two goals. Gibb having won the toss, chose the lower goal, and the game was equally contested in the centre of the ground, our forwards having slightly the best of it, until Maclean, by a most brilliant run took the ball, right through the Richmond team, but being collared behind their goal, the ball unfortunately slipped, and we were thus unable to score this point. After this, one of the Richmond men, after a short run, took a drop at our goal, and which they said, went over it, but many of our men thought otherwise, however we conceded this. After half time, the game was still most evenly carried on, our backs and half backs playing in fine form, until our goal had to succomb to a very fine drop by Michell, this seemed to put Guy's upon their mettle, as they kept the ball down till the end of the game in their opponent's territory, Breach and Gray in especial, playing well. So ended a capital game, in which all luck appeared to have daserted us. Teams:—Captain—Gibb; backs—Breach and Pearson; three-quarter back—Brown; half backs—Maclean, Finch and Gray; Rendall, Gilbert, Wells, Hetley, H. Duke, Wallis, Mutch and Collins.

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Guy's

Hospital Gazette.

VOL. III.—NO. 14. SATURDAY, JANUARY 3, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

We have a little duty to ourselves to perform. An obtrusive little duty, in fact very much so—perhaps more so to our subscribers, and therefore, since it is unavoidable, we approach it with the utmost delicacy. We would not for worlds blurt out, "This is the first number of a new quarter, and"—but stay, we only wished to insinuate in the gentlest manner possible, that Gazettes, speaking generally, depend in great measure upon their subscribers for an existence, and that we, in short, resemble Gazettes in general, much more nearly in this particular than some of our subscribers (!) appear to have considered. To offer this consideration to them was the duty which we hesitated so much to perform, and now we will give Guy's men some reasons why they should support us. Some time ago, when we were more romantic—that is younger, we raised our standard on what seemed to us a very commanding position, the Guyite *esprit de corps*. We had to learn, however, that this *esprit de corps* cared very little what the old school was doing, or to read the thoughts of a fellow-student, or to possess the only journal conducted entirely by students. In fact did not take that interest in our existence which we had expected from it. It soon became evident that *esprit de corps* could not stand twopence a week. It failed us. Of course it did, how could we have forgotten the great boast of Guy's Hospital?—that it produces *practical* men—very practical, they must have their twopen'orth for tuppence. This truth became plainer every day. We determined to act on it, and we are satisfied that a retrospect of the last quarter shows that we have considerably snubbed *esprit de corps*. We have substituted for doubtful leaders, Original Communications from Guy's men, who have gained the highest professional honours. We have cut down windy arguments at the Physical for substantial Clinical Lectures, and for satirical correspondence "Pilocereus Senilis" has supplied us with food for considerable reflection. What *has been* done is a good basis for what *will be* done; in other words, from such a past a startling future may be anticipated. Original communications of great interest have been promised. Clinical clerks intend to send us short reports of their most interesting cases. The Resident Obstetrics will give us a resumé of the month's events of the Charity. The House Surgeons are going to supply us with full statistics of the surgery. While, under the head of Lectures on Medicine, will be published a series of communications, commencing with the Specific Diseases, from a no less renowned pen than that of Dr. Wilks, and which he has written expressly for Guy's men. In fact nothing is required, but that our men should maintain their *practical* characteristic, to make the *Guy's Hospital Gazette* a vast success.

WE cannot permit the opportunity to pass without saying a word about Christmas-day in the Wards. It would probably appear to those who are not acquainted with the matter, that anything like merriment would be out of the question with sickness and pain on every side. But it is not so, even though death does not forsake his accustomed haunt. Yes! against all opposition, many a patient had a merry Christmas at Guy's.

In the morning at one o'clock the Treasurer and Dr. Steele, with a large party of ladies, entered the Wards, which were tastily decorated (there is no doubt but that we should have heartily praised the decorations, had we not seen them before the bright and pretty flowers made by the patients were interdicted); the immense joints of roast beef, and the great plum-puddings had just arrived from the kitchen, and prettily arranged upon another table were the wines and

fruits procured by the contributions of the students, which amounted to more than £20. The party passed through all the Wards, and could but be pleased with the very evident enjoyment of those who were eating their Christmas dinner. After dinner the customary rules were abolished. The British wines were tapped, and the oranges, figs, almonds and raisins, &c., were discussed with much relish; then, as the afternoon wore on, the Wards resounded with mirth and gladness, songs and jokes, and in the male Wards —except one—the pleasant and familiar fumes of tobacco added to the comfort and harmony of the happy groups; nor were the privileges of the mistletoe either forgotten or neglected. The songs were continued till nine o'clock and past, when bread and cheese, celery, and beer concluded a day, which had been a most deservedly happy one to many, for they had determined to enjoy themselves under adverse circumstances, and they succeeded.

CLINICAL LECTURE.

—o—

CASES OF SYPHILITIC DISEASE OF THE ORGANS,

BY SAMUEL WILKS, M.D., F.R.S.,

(From notes by MR. HENRY CLARKE).

(*Continued from page* 84).

Next, we have two very interesting cases of syphilitic disease. One, a woman, and the other a child—a poor, puny, miserable child, with hereditary syphilis. The first case is that of A. H., æt. 25. She is a married woman, but has had no children. She is now very ill, thin, and wasted; has an enormous liver, bad kidneys, and a node on the head—well-marked symptoms of internal syphilitic disease. One point before I mention her symptoms, as to how she obtained the disease. You know it is only of late years that we have known what the terrible ravages of this disease are; how all parts of the body may be affected, and how contrary to what was formerly thought—the blood contains the poison, and the secretions contain the poison. There is no doubt in the world that the secretions are poisonous. It may be conveyed from a woman to a man, when the woman has had no primary sore at all. The poisonous matter may be absorbed by the man through a crack or fissure, and he may get the disease without having had any sore. It may set up a discharge in the man from the urethra, which shall be called a gonorrhœa, but in reality he shall have syphilis. What they get is a urethral inflammation of a syphilitic nature. That shall be taken up into the system and the whole constitution shall be affected. That is how syphilis is often propagated. Women are examined; it is said there is nothing the matter with them, and they are put on one side. But in reality they are suffering from constitutional syphilis. A child, of course, can be affected from the father, and the mother by a syphilitic husband has syphilitic children, and then she gets it. But the question is, whether she can get it apart from pregnancy? Some of our surgeons say it is impossible. It is this that makes the present case of great interest. The woman has had no primary disease, and she has not been pregnant; and the question is, therefore, how she got the disease? Here is a married woman who has not been pregnant, and she has got constitutional syphilis, but there is nothing at all about any primary sore. Now, what are the consequences? What is the effect upon the system? The whole question is changed. There is first the primary sore: the characteristic of that is the induration. Then the glands in the neighbourhood harden, but that is not all. What we know now is that a peculiar change takes place throughout the whole of the body. The bones become affected, and you have lymph thrown out in the periosteum forming a node. The same material is thrown out in the liver, in the lung, and in the brain. In fact, there is no part of the body which may not be affected by it. A person is inoculated with syphilis, and in three or four weeks' time the whole body is infected. During that period the original spot has got hard, the neighbouring glands are getting hard, and there is a tendency for the production of the same material in all parts of the body. This is thrown out, and it may be absorbed by the use of remedies, or a part only absorbed, the rest remaining as hard nodules in the body. There is no tendency to suppuration or softening. We want to know more as to exactly what those changes are taking place in those organs. For many years we have been in the habit of showing nodules in the liver, but the question is whether they are not simply the result of previous changes. My own impression is that there is an infiltration throughout the liver, and by the use of remedies part of this is absorbed, but some that is not absorbable may remain forming these nodules which exist for life. We probably, however, have various forms of syphilitic inflammation. If you look at the testis in a case of syphilis, you may find it in one case streaked with fibrous tissue, in another you find nodules. Probably the same takes place in the liver, and the same in the lung. You may get distinct nodules in the lung; then we recognise them at once, but a question is whether some of the cases of so-called "fibroid' phthisis are not of a syphilitic nature. There may be two forms, then, of syphilitic inflammation—the one where the material is diffused through the organ, and the other where it is found in distinct nodules. You may get all the organs affected, but inasmuch as this gummatous stuff is absorbable when you

give remedies the whole may go away. When the patient has been ill with this a long time he gets into a cachectic condition. Then further changes take place in the body, which are not truly syphilis, but result from syphilis. There is the "lardaceous" "amyloid" or "waxy" degeneration. When a patient has been long ill, especially from disease of bone he gets "amyloid" or "lardaceous" change in his viscera. The change is recognised by the red colour produced on the application of iodine. Exactly how it comes about is another question. However, in cases of long-standing syphilis the patient gets into a cachectic condition, and then dies, not directly from the effects of syphilis, but indirectly. This lardaceous matter is thrown out into all the organs. The true syphilitic gummatous material may have gone or this have taken its place, or it may be mixed with it. Now let me read you the history of this case:—

A. H., æt. 25. There is some history of phthisis in her family. Has been married four years; her husband is living, but suffers from right facial paralysis, deafness, with discharge from both ears; has never been pregnant; menstruated regularly up till last June, but since that time her catamenia have entirely ceased, the stoppage being preceded by a gradual lessening of the quantity; never laid up with any acute illness, and enjoyed very good health till marriage, since has not been strong. About two years ago her belly began, and since has been, gradually enlarging. During that time her symptoms have been pain between her shoulders, vomiting of food, occasionally blood, frequent diarrhœa, getting weaker and thinner. Last July a node appeared on her frontal bone, and about the same time her right femur became enlarged. She has twice suffered from great loss of hair, the hair growing again after each loss. Has suffered from sore throat, and pains in her shins at night. Has lived very well; suffers from piles, and has done for some time past even before marriage. On admission, is a thin, wasted woman, great pallor, dark hair; she has a node on her frontal bone, which has softened down, and there is enlargement of the right femur, extending upwards 7½in. from the external condyle. Liver much enlarged, extending downwards from the fifth rib in the right mammary line for 10in. The surface of the liver apparently perfectly smooth. Spleen cannot be felt, but there is dulness from the 9th rib downwards in the left axillary region. Lungs and heart normal. No œdema anywhere, no lymphatic enlargement, nothing noticeable about her palate. Temp. 97·4, pulse 88, resp. 18. Appetite bad, tongue clear and moist, bowels open; urine—s. g. 1012, pale straw colour, perfectly clear, no deposit on standing, a good ¼ albumen, no casts. To have Hyd. Perchl. cum Pot. Iod. Dec. 8—Left the hospital. No diminution in size of liver; she has never passed more than two pints 12oz. of urine in 24 hours during her stay in the hospital. The s.p. remains the same, but the albumen has gradually diminished down to a $\frac{1}{12}$ albumen. No casts ever found in urine. Other symptoms remain the same as on admission.

Here was a woman, then, who was very ill and wasted, and obliged to keep her bed; and she had an enormously large liver, and the question was, what was its nature? Then on searching we noticed a node on the head, and the right thigh enormously thickened. The urine was examined and found to be albuminous. The woman evidently then had syphilitic disease, then the only question comes, is the deposit in these organs the true syphilitic deposit, and therefore removable by remedies, or has she got a stage beyond that, and is now suffering from the lardaceous degeneration? then there are arguments *pro.* and *con.* You see there is a node on her head, and enlargement of the bone, does not that show that the syphilitic process is still going on? No, it does not; it may be all past, the active process may have ceased, and the deposit may have ossified. Then take the kidney, I am not aware of any active change going on in the kidney in syphilis. We sometimes get gummata in the kidney but it need not interfere with the secreting structure of the organ, and we should not be aware until P.M., that there was a large nodule existing during life. But the kidney is constantly affected in lardaceous disease. Therefore, the kidney being affected, it is probably lardaceous disease, and therefore the chances are the liver is also of the same kind, so she has probably got beyond the true syphilitic stage, and has got into the tertiary stage, or the sequelæ. The question is then as to treatment. We thought we would give her the benefit of the doubt, and employ syphilitic remedies, so we ordered 1 oz. of the perchloride and 10 grs. of the iodide. That is one of the best ways of giving the bin-iodide of mercury.

(*To be continued.*)

We are glad to learn that Mr. Sandy, the electrician of Guy's, has taken premises at 34, King Street, for the sale and manufacture of the galvanic appliances.

INVALID CLIMATES.—A comparison of three places of invalid resort, Mentone, France; Aiken, South Carolina; and Anaheim, in Southern California, for the months of December, January and February, has been made says the *Medical and Surgical Reporter*, by Francis S. Miles, of New York. He says that at Anahelm an invalid could have been out of doors all day during 81 days, and would have been confined in doors by bad weather 9 days. At Mentone there were 67 fair days and 23 bad days, and at Aiken 53 fair days and 37 bad days. The average temperature at Anaheim during the three winter months was 61 degrees, at Mentone 48½ degrees, and at Aiken 53 degrees.

LECTURES ON MEDICINE.

—o—

SPECIFIC OR ZYMOTIC DISEASES.

BY DR. WILKS.

(*Continued from page* 101.)

Before taking each of these separately, I shall first speak of them as a whole, and you will then perceive what features they have in common. The most approved theory is that each owes its origin to a specific or peculiar virus, which, being introduced into the system, propagates therein, and reproduces itself to an almost infinite extent. This process is attended by certain characteristic phenomena, and as a rule, the subject of it cannot undergo the process a second time. These facts suggested to Liebig the idea of a fermentation in the blood, whereby a certain material (like sugar or starch) might undergo a fermentative change, and that when the process was ended with the destruction of the agent it could never occur again. Upon this hypothesis he framed the word "zymotic" (*zumoo*, I ferment), a term still retained, although the idea attached to it is not generally held, but used synonymously with the expression "epidemic." An explanation by others of a non-recurrence of a specific disease is found, not in the idea of fermentation, but of growth, whereby the virus introduced into the blood grows at the expense of a certain material within it. These two theories, however, may be identical if the growth of the yeast plant and fermentation are considered together.

We use the term "specific" to designate these diseases, because we believe each one stands isolated from the others, in the same way as a plant or animal is distinguished from all others, as having a different parentage. Just as in the organic world every example of tree or beast produces its like and no other; so amongst these diseases—small-pox produces small-pox, scarlatina produces scarlatina, and none other. Then there is the absolute proof that if the virus of one of these diseases be inoculated into a healthy person a similar affection is produced in the latter. We have, therefore, every reason to conclude that whenever we meet with an example of a specific disease that the germ of the disease has been implanted in the subject of it, just as when we see a weed in our garden we believe the seed must have been sown. There are also many other arguments in favour of the belief of the specificity of these diseases, and more especially those drawn from their history in different countries. As, for example, although the climate is the same as it has ever been, yet it was only three years ago that scarlatina appeared in India and parts of Australasia after the arrival of a ship with cases of the disease on board. Small-pox was unknown in America until the conquest of Mexico, when, on being introduced, millions fell victims to its virulence, and the same with syphilis in the Pacific Islands. The importance of these questions arises from the fact that it is only in the minority of instances of specific diseases that we can trace contagion, and yet I must advise you to consider that in every case the disease has been "caught." In the present state of our knowledge you have a right to assume that, even though you are unable to prove it, and let the *onus probandi* lie on those who maintain the spontaneous generation of these diseases, as it is for them to prove their position.

You can understand why the specific cause of these diseases is spoken of as a poison, since in the animal and vegetable world a poison means that which produces certain definite and distinctive injurious consequences; so peculiar, that when meeting with these symptoms in any individual case, we immediately recognise the causes which are in operation. If, for example, a small quantity of arsenic be administered to a human being he is immediately seized with vomiting, purging, collapse and very definite symptoms; if, instead, he swallowed the cholera or contagium poison very similar phenomena would ensue.

It is, therefore, held that each disease has its cause or active principle, which is called the "contagium," and the time may come when a future lecturer may place before his class several bottles labelled "vaccine," "varioline," "typhine," "cholerine," &c. That this contagium is not merely a homogeneous fluid, but contains distinct germs, is proved by diluting it, when it is found that after many experimental trials at inoculation a certain number of these only are successful, showing that these germs are accidentally caught. It is generally believed that these germs are produced in the animal organism, and are therefore living particles or "zoosperms"—that they can only be propagated in the subject of the disease, and therefore it is possible that all these zymotic disorders might be stamped out by isolating patients, just as the cattle plague is stamped out by killing the animals.

There are those, however, who, holding to the specific nature of the "contagium," believe rather that it is of a vegetable kind, and therefore can have an altogether independent existence outside of the animal body. They would contend that the poison of cholera was a rice fungus, that of measles the same as a well-known mould, that typhoid fever poison was produced by vegetable decomposition, and so on. I might also say that those who believe in the spontaneous origin of these diseases are in the minority, but they would hold that typhus fever is produced by overcrowding, relapsing fever by impoverishment, typhoid by vegetable decomposition, cholera by an exaggeration of the circumstances present in our autumn months, scarlatina by decomposition of blood, and even small-pox (according to Miss Nightingale) by bad sanitary conditions. Syphilis would be said also to arise *de novo* from promiscuous intercourse.

I give you these opinions, not with the object of forcing any one of them dogmatically upon you, but that you may know what the theories are, and that you may reason logically and clearly upon them; that you may not raise a cry against the dirty river in your town whenever scarlatina, typhoid or cholera appear, unless you can explain in what way you hold it to be guilty of their production. At present the prevalent opinion would be that the river merely acted as a conveyer of distinct and separate poisons at different times. The proof apparently lies in such an example as is given by the Medical Officer of the Privy Council. A notoriously dirty and ill-drained village, where the wells are frequently contaminated from the offensive ditches, is free for many years from typhoid fever until a case of this disease is brought into the place, when immediately it spreads widely amongst the inhabitants. The means of conveyance is at hand when the poison arrives.

Now let us see what happens when a specific virus is introduced into the system. It immediately infects the blood and commences to produce some change in the way of altering its constitution, whilst it itself is being infinitely propagated. This is the hatching time or period of "incubation." As a rule the subject of it is not conscious of the change, and therefore is not ill. When a virus is inoculated we see a local inflammation going on, as after inoculation of small-pox, where the pustule is forming eight days before the constitution is seen to suffer; or after

inoculation of syphilis where an induration goes on at the spot, and after forty days the constitutional symptoms appear. It is most probable that if the virus of other diseases were inserted directly into the system that the incubating time would be definite, but the mode of and introduction differs in so many ways that this period varies considerably in each particular case. It may be due to the mode in which the virus is introduced, the latter being less able to penetrate the system in one direction than another. Thus small-pox virus inoculated affects the system a few days before it would do so if taken in by the lungs as vapour; so the secretion of measles acts more rapidly than the vaporous emanations of the skin. I must therefore take the extremest and narrowest limits, and give you the average. The importance of this question is brought before you when you are asked, for example, by a mother at what time she is safe from infection after having left nursing her sick child.

When the incubation is complete the whole body becomes affected by being thrown into a violent febrile state, in which every organ of the body suffers. At the same time the surface of the body, both the skin without and the mucous membrane within, shows marked signs of irritation, and since on these surfaces the poisonous secretions often appear it is thought that the latter are eliminated by these sources. The alterations on these surfaces are peculiar, and more than other symptoms assist us in identifying the disease: such as the peculiar rashes of the exanthemata, and the affections of the ileum in enteric fever. All the solid organs likewise are affected by the poisoned blood, as indicated by their deranged functions seen in the delirium, sickness, diarrhœa, yellow skin, or albuminous urine. The organs are filled with blood, which is often undergoing a solution, and thus hæmorrhage occurs within them as well as on the surfaces of the body. We meet, therefore, with what are called malignant forms of the specific diseases in which this hæmorrhagic tendency is often the principal symptom.

I would ask you, therefore, to think of these specific diseases as a whole, by which you may remark in what particulars they resemble one another, and you will not be led into error when a new epidemic arises, either amongst men or the lower animals. You will not assert, because in the rinderpest an eruption is met with, the disease is small-pox; or because ulceration occurs in the intestine that it is typhoid fever; nor will you necessarily think that an epidemic amongst pigs is scarlet fever because the skin is red.

I will conclude with a word about treatment. As far as it is at present known there is no cure for specific diseases; they run their course and cannot be cut short. At least, at the present time there is no evidence in proof of it, although we are constantly trying every new remedy which is suggested for the purpose, such as belladonna for scarlatina, sulphurous acid for typhoid, or sarracena for small-pox. Whether, after inoculation on the surface of the body, the constitutional disease could be modified by destroying the focus of contagion at that spot is questionable. I am not aware that any experiments were made in rubbing out the small-pox pustule during its development in the time of inoculation, but it was the opinion of Hunter and some modern surgeons as regards syphilis, that the early treatment of an indurated chancre would modify the secondary symptoms. All we do at present in these specific diseases is to assist Nature, and relieve any especially untoward symptoms. We place the patient in as good air as possible, so as to dilute and carry off the poisonous effluvia, and give him cooling drinks. At the same time we may give medicines to relieve a bronchitis or check a diarrhœa, and quite recently it is believed that we may do more than this, for we have begun to regard the increased temperature in the febrile state, not as a necessary part of the process which must be gone through, but as a condition which is positively injurious, and therefore may be checked with advantage. The plan, therefore, of placing our patients with typhoid fever in cold baths is undergoing a trial.

Disease.	Incubation.	Premonitory Fever.	Duration of Rash.	Mode of Contagion.
Typhus -	Average 9 days, few days more or less	4	10	Exhalation from body and lungs, from clothes
Typhoid -	12-14 days or less - - -	10	14	Secretion from intestine, inhaled or swallowed
Relapsing	Probably 4-5 days - - -	17		Exhalation from body and lungs
Small-pox	12 days, when inoculated 8 days -	2	8	Exhalation from body and lungs, from clothes, purulent secretion and scabs
Scarlatina	3-6 days or less - - - -	1	3	Exhalation from body and lungs, from clothes, blood, epithelial scales swallowed or inhaled
Measles -	10-15 days, when inoculated 7 days	3	4	Exhalation from body and lungs, from clothes, blood, secretion from nose
Syphilis -	30 days - - - -	Few days.	Several weeks.	Blood and the varies secretions

Before speaking of the so-called fevers, I might remind

you that the distinction between typhus and typhoid has only been made of late years, and this is the reason why I give them together and contrast them together. There was a time when the most conflicting opinions existed in the three capitals of Great Britain and that of France respecting the nature of fever. In Paris it was maintained that an intestinal affection was the seat of the malady. In Dublin the intestine was pronounced to be healthy, while in London two varieties were described, just as the bowel was or was not affected. The difficulty was cleared up by the demonstration, that under the name "Fever" several maladies were included, such as typhus, typhoid, and perhaps other forms. I shall begin with typhus.

MEDICAL WARDS.

—o—

The following cases were admitted from Dec. 24 to Dec. 31, 1873.

JOHN (Clinical).

1—Poisoned by Arsenic
7—Phthisis
12—Bronchitis—Emphysema

MIRIAM (Clinical).

17—Amaurosis
19—Amaurosis
22—Typhoid
24—Typhoid
30—Heart Disease (Presystolic Bruit)
31—Maltrurition

PHILIP

4—Phthisis
21—Bronchitis—Dropsy
30—Sciatica
31—Rheumatism
37—Heart Disease (Regurgitant Bruit)

STEPHEN

1—Partial Paraplegia
6—Phthisis
13—Bronchitis
29—Angina Pectoris (?)
32—Alcoholism (?)

MARY.

1—Morbus Cordis
10—Typhoid (?)

ADDISON.

25—Typhoid
28—Aphonia
35—Aphonia
38—Mitral Disease

ASTLEY COOPER (PETERSHAM).

23—Erysipelas—Bright's Disease

SURGICAL WARDS.

—o—

The following cases were admitted from Dec. 24 to Dec. 31, 1873.

ACCIDENT.

3—Fractured Tibia and Fibula—Delirium Tremens
4—Concussion
27—Concussion—Epileptiform Convulsions
29—Fractured Tibia and Fibula

CORNELIUS.

5—Compound Fracture of Left Tibia and Fibula by Machinery—Supra-condyloid Amputation

LYDIA

13—Ulcer on Inside of Thigh—Syphilitic
24—Old Necrosis of Skull—Protruding Meningocele (?)—Encephalocele (?)—Sloughing Tumour of Scalp (?)

MARTHA

4—Crush of Chest—Injury to Lung of Pleura—Laceration of Diaphragm—Displacement of Heart
5—Sprain of Leg
6—Fracture of Fibula
8—Abscess near Shoulder
10½ (Cot)—Burns—Death
10 (Cot)—Burns

NAAMAN.

No Admissions.

LAZARUS.

9—Contusion to Knee
12—Papilloma of Left Thumb
13—Perinæal Section for Retention of Urine
19—Fractured Base—Death
20—Stab penetrating Upper Lobe of Left Lung—Emphysema
21—Contusions
22—Old Injury to Wrist

JOB.

6—Epithelioma of Tongue
18—Stricture
21—Injury to Knee

LUKE

7—Traumatic Phlebitis
11—Enlarged Prostate, Retention of Urine
17—Dislocation of Lower End of Femur—Ostitis (?)—Myeloid (?)
21—Disease of Hip

DORCAS

10—Carcinoma Mammæ
22—Enlarged Bursa Patella
26—Talipes Equino-varus

CHARITY.

5—Tumour of Arm
15—Superficial Gangrene of Leg

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

NEW APPOINTMENTS.

HOUSE PHYSICIANS.—January to June—Mr. J. Lacey Morley March to August—Mr. W. H. A. Jacobson; May to October—Mr. H. Ashby.

HOUSE SURGEONS.—January to April—Mr. H. Hetley; March to June—Mr. F. T. Paul; May to August—Mr. T. D. Ransford.

On duty for the month ending January 31, 1874.

HOUSE PHYSICIANS—Mr. R. J. Pye-Smith and Mr. T. Eastes
JUNIOR HOUSE PHYSICIAN—Mr. J. Lacey Morley
HOUSE SURGEON—Mr. W. H. A. Jacobson
JUNIOR HOUSE SURGEON—Mr. H. Hetley
RESIDENT OBSTETRIC ASSISTANT—Mr. H. Ashby
JUNIOR RESIDENT OBSTETRIC ASSISTANT—Mr. F. T. Paul

APOTHECARIES' HALL.

On Thursday, January 1, Mr. W. Williams, M.B. Lond., M.R.C.S., L.R.C.P., and Mr. F. T. Paul, M.R.C.S., L.R.C.P., were admitted Licentiates of the Society of Apothecaries.

NOTICE BOARD.

There are several vacancies for Externs during the present month. Applications should be made at once to Mr. Stocker, or the Junior in the Charity.

Will be published in a few days, 24 pp. Demy 8vo., Toned paper, price 1s 6d, post free 1s 7d.

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"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER at 104 Borough High-street, Southwark, Surrey.—Saturday, Jan. 3, 1874.

Guy's Hospital Gazette.

VOL. III.—No. 15. SATURDAY, JANUARY 10, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

TO-DAY the members of the Guy's Football Club recommence their matches after an interval of three weeks, and if they do as well after Christmas as they did before, the result will not be unsatisfactory.

Nine matches have now been played, and of these Guy's have won five, viz., those with St. George's Hospital, The Arabs, London Hospital, Clapham Rovers, and King's College Hospital; they have lost two, viz., those with Blackheath and Richmond: and two have been drawn, viz., those with St. Mary's Hospital, and University College Hospital, but of these two the former was greatly, and the latter slightly, in favour of Guy's.

The match to-day is the return with Blackheath. We notice one or two veterans are to play, and we hope the result will be better than on the last occasion, when, it may be mentioned, Guy's played without two or three of their best men.

We observe that the men elected to represent Guy's in the trial matches for the All England teams are Pinching, Maclean, Gray, and Gilbert; Pearson also has been elected by Clevedon, and Welchman by the Flamingoes. The first of these trial matches took place at Blackheath last Wednesday, when, doubtless owing in great measure to the beautiful weather, a great many spectators witnessed the play.

Three Guy's men were engaged, viz., Pinching (forward), Gray (three-quarter back), and Pearson (back). We believe Maclean and Gilbert were also arranged to play on that day, but for some reason or other they were absent. The play was not very startling. Pearson made some good drop-kicks, and Gray ran in once and made a touchdown, but the Guy's men did not play up to their usual form. We are in great expectation, however, that Guy's will have at least one representative in the English Twenty.

THERE occurred in our last a paragraph in reference to the "Notes on Specific Diseases" from lectures by Dr. Wilks, which, having been taken somewhat too literally, has led to a little misunderstanding. The matter is a mere quibble of words. but to those disposed to quibble, we advance this explanation—that, the *Guy's Hospital Gazette* being a Student's journal, the staff do not contribute to it; and, that Dr. Wilks is not publishing his lectures, but has generously placed his notes in the reporter's hands, to ensure that the report shall be correct. We have deemed it advisable to publish a number of lectures during the past session, and we believe this to be in accordance with the wishes of our subscribers. At the same time we are sure that they will agree with us in refusing to publish such matter, if there be any objection to such supervision on the part of the lecturer, as shall make him responsible for the statements published as his.

CLINICAL LECTURE.

—o—

CASE OF SYPHILITIC DISEASE OF THE ORGANS, AND ONE OF HÆMATURIA.

BY SAMUEL WILKS, M.D., F.R.S.,

(From Notes by MR. HENRY CLARKE.)

(*Concluded from page* 107).

The case of the boy is one of hereditary syphilis. This is one of great interest. What we know of hereditary syphilis is altogether new. It is only since Pathology has become a science that we have really known what syphilis is. Medical men were content formerly with just looking

at the outside of the body. We divide our art into Medicine and Surgery, which brings many evils with it. There is many a patient under the physician for months and months, whom the surgeon would cure in a few days, and there has been many a person with a constitutional disease, like syphilis, who has been treated from a purely local point of view. One can see very well why it is propagated in a particular manner, but you must eradicate from your minds the idea that it is necessarily a sexual disease. The notion was formerly that it was purely a local disease, and a sexual disease, and it used to be treated by medical men who saw simply the sore and the bubo. They looked into the throat, and as far as they could see they found ulceration, and perhaps at the other end of the body they found condylomata of the rectum. As far as the sight could reach, the disease was traced, but not further. You have only, however, to look inside the body, and you find it. About the same time that internal syphilitic diseases were discussed the subject of hereditary syphilis was also investigated. It was known that a child born of syphilitic parents had syphilis, and the notion was that the child either died, or, in a few months was cured. But it has only been known of late that the child having the poison in its system, would subsequently develope in itself all those changes I have mentioned. When it got to the age of nine or ten it would have an affection of the eye, which would formerly have been called "strumous ophthalmia," but which was nothing more than a syphilitic affection, and which, as you know now, is cured by syphilitic remedies. Other changes also take place, ulceration occurs in the throat, nodes come on the bones, and just as though the person had acquired the disease: and more than that, they will occur at a period when they might have acquired it, at the age of twenty or more. But then you may say,—How will you distinguish between the two? In this way—When children have hereditary syphilis badly the whole frame is affected so, that the child, you will see, is dwarfed, only about half the height it ought to be. The whole system is also affected, and in a particular way. These children have stomatitis. They have snuffles. Inflammation, very often of the periosteum and the mucous membrane over it. The whole body undergoes a change. The head often becomes enlarged, the forehead prominent, and the nasal bones sunk in. Then, as you know, the permanent teeth undergo a change. This boy has not that change very well marked, but in some you see it very plain. The "notching" is not of much importance, but the whole teeth are dwarfed and smaller than they should be. In a natural incisor, for instance, the end is broader than the base, and also convex. But in a syphilitic child it is exactly the opposite—the end is smaller than the base, and the edge concave instead of convex. The canine teeth, too, are very small and pointed, forming the so-called "pegged" teeth of syphilis. With regard to this boy, then, I say his whole appearance would suggest at once that he is the subject of syphilis. He has had keratitis, and probably also iritis, and some other affections, as well as the whole of the structures of the eye being affected. He has slight notching of the teeth and a great big liver, with some large lumps in it, no doubt due to syphilitic nodules. The following is the history:—

T. D., æt. 14, was admitted into Clinical Ward, Nov. 27, 1873. Patient was in Clinical in the summer, with a circumscribed tumour of liver, which was punctured and found to be solid; it disappeared during his stay in the hospital, but returned again about four months after his discharge. He is the subject of well-marked congenital syphilis, being stunted in stature, with evidence of old corneo-iritis, and extensive ulceration about the fauces and soft palate. His only complaint is of the pain caused by the large size of his liver, which reaches down to his umbilicus; on its surface are four well-defined nodules, but besides these growths there is evident general enlargement of the organ. He has no albuminuria, but a little bronchitis. He was ordered Pot. Iod. gr. v., Aquæ oz. j. t.d. He remained in the Hospital four weeks, during which time his liver rapidly decreased in size.

I will allude to one other case before I close, because this is also a good typical case. It is called Intermittent or Paroxysmal Hæmaturia or Hæmatinuria. It has long been known that patients are in the habit of passing blood in their urine, for which we do not know the cause. He may have a stone in the bladder or kidney, or other disease, in which bloody urine is merely a symptom. But without any such cause, a patient may suddenly pass blood. And there is one form which is very characteristic; that is the paroxysmal form. The peculiarity of it is, that it is merely the colouring matter of the blood that is passed and not the blood itself. Another peculiarity is that these patients are one day well, and another day ill. There are very few symptoms, except those which resemble ague, and it has been suggested that ague poison may be at the bottom of it; it may occur after a jolt in a railway carriage, or exposure to cold. The attack is sometimes preceded by slight shivering. In some cases it comes on every other day. You look at the urine, and at first sight it does not look altogether like blood—it is brownish. On examining it with the microscope you find this brown stuff is only the colouring matter of the blood. All you find is a quantity of *débris*. If you put on a higher power some of this is seen to be composed of hæmaturic crystals. Sometimes you find them formed in roundish or oval masses, showing it has come from the kidney, that is, you get casts of the kidney. And

this all you find. You may find sometimes urine of a similar character in patients who have died of blood-poisoning, or typhus and scarlet fever, &c., but in cases like this it is supposed to be a primary affection of the kidney. In some cases it is not so paroxysmal, and we find there is a special cause for the attack. When this patient was admitted Mr. Chicken examined the water and found it healthy. On the next day, the 27th, he went out for a walk in the park, and immediately passed some urine almost as dark as porter.

Here is a disease you must recognise. We find as a rule they are to be cured by tonic remedies, such as quinine and iron. Sir William Gull had a case here, and he suggested as a kind of hypothesis, that it was something intermediate between a healthy kidney and a real nephritis. In a healthy kidney you have hæmaturia in the form of colouring matter. The colouring matter of the urine, in other words, is nothing more than the blood corpuscles broken up. Now take a case of nephritis, and you get the blood corpuscles escaping whole. Now if you can imagine an intermediate condition when the blood corpuscles are broken up, but not sufficiently so to form the ordinary colouring matter of the urine, but simply thrown out as hæmatin, then you would have this disease. He did not say this was what occurred, but you might imagine that not only was there an extreme disease called nephritis, but there might be modifications of it, and some such modification you would have in hæmaturia.

LECTURES ON MEDICINE.

TYPHUS.

BY DR. WILKS.

(*Continued from page* 101.)

Typhus has an incubation of nine days. In a carefully-observed epidemic some years ago the average time was found to be eight days; in another epidemic the incubation period was reckoned at twelve days, but you may remember nine as the average time. At its termination the febrile symptoms set in violently; there is pain in the limbs, great lassitude or prostration, intense headache, and total loss of of appetite; fever heat of 104 deg. is often reached on the second day.

After three days of extreme fever the characteristic symptom appears—the so-called mulberry rash. At first this is bright, and, like other exanthems, fades on pressure; it is indeed like measles, and thus has been styled the measly rash. It is first observed on chest, abdomen, and arms, and then spreads all over the body. The term mulberry denotes an appearance as if mulberry juice had been squeezed on the skin, whereby the whole surface would have been universally discoloured. At the same time the juice by collecting in drops would have formed larger spots intermixed with the more general staining. If, therefore, you look at a typhus rash you perceive that the skin is uniformly discoloured by a purplish exanthem, and scatterd all over this some larger spots. The latter have no definite shape, and are with difficulty isolated by the eye, consequently there is nothing about them characteristic, and the rash in typhus must be judged of as a whole. If the diagnosis cannot be at once made no further investigation will unravel it. This rash lasts ten days; for the first few days it fades on pressure, after that it becomes darker and ceases to fade; the blood stagnates in the capillaries and can no longer be squeezed out. In very bad and fatal cases more than this occurs—some of the blood exudes into the tissues, leaving a blackish spot; in this way the body and legs are covered with "petechiæ" and sometimes large bruise-like patches form called "vibices." In this case the petechial remains after death, whereas every exanthem necessarily fades.

When on the fourth day the rash appears, the fever with the accompanying symptoms continue, the patient getting necessarily more prostrate day by day; he is drowsy, and deaf, or delirous, tongue brownish or reddish at edges, respiration quickened, and perhaps some little bronchitis, pulse 120-130, bowels perhaps confined, and urine high colored. All the functions of the body indeed are disturbed. The brain shows it by all mental power having gone; if the patient be roused to answer he immediately sinks into the same lethargic state again, and speaks with difficulty and slowly, In fact he is in what is often called the "typhoid" state, characterised by extreme muscular and nervous debility. At the end of about fourteen days these symptoms rapidly abate together with the eruption, and convalescence begins. From the height of the fever to its fall from 36 to 48 hours or less elapse. Thus it may be said that the rise of temperature is quick and the deferrescence is also quick.

If the case should not end favourably, all the above symptoms become more severe—the rash becomes petechial, as above-mentioned. The prostration is greater as observed by the patient lying on his back sunk down in bed, with his arms often outside the clothes, scarcely sensible and unable to speak, quite incapable of being roused, with constant muttering, great difficulty in swallowing, constantly picking at the bed clothes or at imaginary flies. Pulse very rapid, 140-150, and when felt the muscles are found to be jerking, producing "subsultus tendinum." Patient does not sleep, but lies with his eyes open in a state which is called "coma vigil." The bladder is distended. Bowels act involuntarily, and death soon ends the scene

With regard to some of these symptoms individually, the paralysed bladder must be especially noted; also the weakened tone of the heart, making the first sound scarcely audible, and it beating more than 140 per minute denoting a condition rarely recovered from. The sinking-down in bed indicates the inability of patient to raise himself up on his pillow. Congestion of lungs known by expectoration of mucous tinged with blood, and the polluted air from them, may be noted by catching the ammonia on a slip of glass wetted with hydrochloric acid. Occasionally convulsions are observed, and these may occur in connection with albumen in the urine, but also without it. Occasionally swelling of cervical lymphatic glands. On *post-mortem* examination nothing characteristic is found; the blood is liquid, filling all the organs which are at the same time soft. Petechial spots are observed on the skin, as well as on the internal surface of the body, and on the coverings of organs.

Prognosis.—Cœteris paribus, this is according to age; that is all young persons when placed in favorable circumstances recover whereas all old persons die. I believe the age of forty would be about that in which the chances of

recovery or death are equal, but above this age the risk rapidly increases, and in my own personal experience I never saw a patient above fifty recover.

Causes.—Believed to be specific; but is remarkable that typhus is only observed amongst the poor when crowded together in the courts and alleys of large cities. Than it is not seen amongst the better classes of society except clergymen and doctors, who of course have caught it in their vocation. These facts have given rise to the belief that the poison of typhus may be self-generated, and certainly there is much to be said in favor of this view. For instance, it was formerly known as gaol fever or ship fever, and was thought to arise whenever dirty people were crowded together in a small space. In the case of a gaol, there was no proof that the specific poison had not been introduced; but in the case of a ship at sea, this could not have occurred; but it is remarkable that I can find no authenticated instance of the disease breaking out at sea, and after the ship had been a long time from port. The prison fever was certainly very remarkable from the virulent nature of the poison, and the rapid progress of the contagion. Thus we read that at an Old Bailey assize, about a century ago, forty persons were stricken with fever, and several died. Those who were seized were the Lord Mayor, and one of the Judges, several officials and strangers. It states that the windows were open on one side of the Court, and it was those only who caught the breeze, on the other side who were smitten. The disease is thus highly contagious, but probably the poison dies with the patient.

The *diagnosis and treatment* I shall reserve until I speak of "Typhoid."

MEDICAL WARDS.

—o—

We have to thank Mr. H. Williams for the following report of a case of

ANEURISM OF THE ARCH OF THE AORTA.

J. S., æt. 45, was admitted into Clinical Ward, November 26th, 1873.

Patient has been a coachman for the last five years. Before that he was in the Horse Artillery and served in the Crimea. During his service in the army he had gonorrhœa, and what he calls "secondaries," but these seem to have been swollen testicle, and a bubo. His general health has been capital. His habits have been regular and steady, he has two good conduct medals. His mother died from dropsy, his father from old age; no phthisis in family. He was quite well in the spring of this year, but this summer he has had to push a heavy mowing-machine besides doing his ordinary work as coachman and gardener, and while doing this he has several times felt acute pain in his abdomen as though something had been torn. His breathing became bad, he had pain in his left side with cough and expectoration, but owing to having a wife to support he did not leave off work until five weeks ago, when he became so weak that he was compelled to give up. He came to the Hospital three weeks ago to apply for admission, but was not successful until yesterday. Never any hæmoptysis.

On admission.—Patient is an old-looking man for his age, is thin and pale. He complains of pain across the abdomen, which only comes on while he is moving about, he being quite free from it when lying quietly in bed. He says it is sharp and shooting and worse when he coughs. He has lost flesh lately, especially in his legs. Cough is bad at night, preventing sleep, sputa are masses of thick greenish pus floating in brownish watery mucus. No night sweats, he always feels chilled. His face is slightly dusky, and his finger ends are clubbed with the nails curved over them, bowels regular, no diarrhœa, appetite good, tongue moist slightly furred. He has no pain in chest. Passes a good quantity of urine daily. Chest on inspection is seen to be much sunken on the left side, it is flattened both in front and behind, and the normal curve of ribs at the side is made more acute. Measurement of left side from sternum to spine through nipple 12½in.; ditto, right side 16½in. The left side is everywhere resonant on percussion, and expands in respiration as much as can be expected. The heart's impulse cannot be felt in its proper place, but it is found to beat between third and forth rib about 1½in. to right of sternum. The sounds are healthy. Percussion note on right side very fair. Vocal fremitus distinct everywhere, but more so on right than left side. On auscultation there is vesicular breathing over left lung, except at base before and behind, where there are moist sounds at end of and masking inspiratory murmur. On right side at upper half, inspiration is loud and coarse, expiration is inaudible, below the fourth rib there are moist sounds; auscultation behind, ditto. No bronchophony. Liver dulness begins very low, almost at margin of ribs, and extends down 2½in. Urine sp. gr. 1020, no albumen nor sugar. He complains of pain in the abdomen, but beyond some tenderness on pressure, I cannot find anything wrong. He has no pain after taking food. To have Tinct. Opii and Mist. Cascar. 1 oz. t. d.

Dec. 3—In my first report I said the heart sounds were healthy, but on listening to-day I hear a diastolic bruit at the second right costal cart. and popagated downwards, and to the right in a direct line with right nipple. His pulse is weak, regular and somewhat "kicking" in character.

Dec. 10—Patient says that the pain on left side of abdomen was very bad last night, preventing sleep. It is shooting, beginning in left kidney and running down in course of left ureter to the bladder. Urine sp. gr. 1020, no albumen nor sugar.

Dec. 12—Patient has taken cold, and has an attack of acute bronchitis; his cough and expectoration are worse, he has orthopnœa, and is face is congested. There is crepitation to be heard over both lungs, with both inspiration and expiration, and sibili; no dulness on percussion, no bronchophony.

Dec. 16—He is much better again, the cough is much easier, expectoration less; and his r spiration easy and free.

Dec. 26—Patient was again seized with urgent dyspnœa to-day; his face became livid, his speech difficult and he seemed as though moribund. Rhonchi and sibili and moist sounds are heard all over his right side, in fact there is a perfect chorus of sounds. After the dyspnœa had lasted a few hours, it gradually subsided.

Dec. 30—I think there is a pleuritic rub just outside right nipple. He complains of catching pain on inspiration. His dyspnœa is less urgent this morning.

He was taken worse, and died on January 3rd, at noon.

Sec. Cad.—Right side of heart rather bulging; right ventricle capacious, full of liquid blood; only slightly hypertrophied. Great aneurismal dilatation of ascending part of arch of aorta—No hypertrophy of left ventricle.—(Heart occupied its normal position, so that it was evidently the pulsation of the dilated aorta that was felt during life on the right of the sternum). Two of the aortic valves

were adherent to each other; the other was much lengthened. Water poured into the aorta from above passed into the ventricle. Aorta atheromatous. Weight of heart, 15 oz. Left lung collapsed. Pleura showed abundant traces of old inflammation. Upper $\frac{1}{3}$ fixed by firm adhesion to chest wall, lower $\frac{2}{3}$ entered into formation of a cavity, which contained thick yellow lymph. A large calcareous plate lay on the anterior surface of the lower lobe of this lung Right lung emphysematous. Bronchial tubes widely and irregularly dilated up to the very surface of the organ, containing purulent fluid. A quantity of tubercle at apex. Liver very tough, cirrhotic; a small calcareous concretion at lower part of anterior surface of left lobe. Small hard spleen. Kidneys healthy.

The following cases were admitted from Jan. 1 to Jan. 7, 1874.

JOHN (Clinical).

1—Acute Tonsilitis
8—Hemiplegia

MIRIAM (Clinical).

20—Bright's Disease
31—Constipation

ASTLEY COOPER

2—Locomotor Ataxy
8—Intestinal Irritation

PHILIP

1—Incipient Phthisis
4—Phthisis
5—Mollities Cerebri
23—Syphilis
24—Phthisis
31—Aortic Disease
36—Phthisis
46—Phthisis

STEPHEN

3—Osteo-arthritis
15—Diabetes Mellitus—Albuminuria
17—Jaundice
21—Bronchitis
31—Pleurisy
38—Cerebral
45—Lead Poisoning
46—Phthisis
50—Subacute Rheumatism

MARY.

7—Dyspepsia
14—Albuminuria (?Lardaceous Disease)
20—Pleurisy
22—Obesity

ADDISON.

9—Chorea
11—Typhoid
22—Chorea
22—Gout
33—Hydrocephalus ?

SURGICAL WARDS.

—o—

The following cases were admitted from Jan. 1 to Jan. 7, 1874.

GUY'S HOSPITAL LIBRARY

ACCIDENT.

5—Concussion
12—Concussion
—Compound Fracture of Left Thigh—Amputation—Death

CORNELIUS.

1—Injury to Head—Bronchitis
12—Fracture of Tibia and Fibula
15—Fractured Femur—Delirium Tremens
16—Concussion—Delirium Tremens
20—Fracture of Tibia and Fibula

LYDIA

2—Fracture of Ilium in Child ?—Separation at Right Sacro-Iliac Synchondrosis ?
4—Sinuses about Rectum
7—Lupus of Nose ?—Perforating Ulcer of Throat
14—Enlarged Gland in Groin—Hernia ?
22—Contusions of Legs

MARTHA

3—Synovitis of Left Knee
16½ (Cot)—Abscess in Calf

NAAMAN.

No Admissions.

LAZARUS.

23—Sinus in Thigh

JOB.

No Admissions.

LUKE

3—Periostitis of Arm
4—Hernia
7—Ulcer of Knee—Specific ?
12—Epithelioma
13—Necrosis
14—Scalp Wound

DORCAS

No Admissions.

CHARITY.

3—Fracture of Femur
4—Ulcer of Leg
13—Ulcer of Leg
18—Tumour of Breast
19—Fracture of Tibia and Fibula

BARNABAS (Ophthalmic).

4—Closed Pupil
12—Glaucoma
15—Cataract

RUTH (Ophthalmic).

31—Strabismus

ANOTHER fossil man has been discovered at Mentone.

LIBERTY AND WASTE.

How loudly we cry out for Liberty of thought. Now Liberty Is a thing that no one has ever yet understood, and the more you think calmly about it the more you are inclined to guard and limit the glow the word excites. Certainly if Liberty of action is a thing to be feared, Liberty of thought is more to be feared; for your actions meet with other people's actions, which check them and keep them in a path of reasonable safety. But thoughts can live *in vacuo*, and they may become ever so licentious and wild there. It is also true that the Thoughts so wild may become Fathers to deeds which, while they inherit the parental wildness, enter on an existence in the hard world of things, and then, like those ancient sons of Jupiter, commit their Father's crimes without their Father's security from consequences. But we must not speak against the Liberty of Thought in the *Guy's Gazette*. Who shall dare prescribe limits to an Englishman's loving worship of Liberty?

Something in every Englishman's heart admires the good Bishop who would "rather see his country free than sober." (Whether it is sobriety or freedom that moves this admiration we won't stay to inquire.) But in our worship of Liberty let us take into account the sacrifice a complete liberty compels us to make. Let us look at the negative side of Liberty. What it takes away. Suppose all the youths grow up in personal freedom and self-dependence, and have no reliance apart from their own private judgment. What then do they lose? You will see that they lose the fruits of the greater part of their nature. How? Don't you see. Think, then, how much of each of us lies waste and unused, because his individual motives don't furnish "go" enough to employ the powers he has? To use this waste (the larger part of most of us, by the way) it needs that one's individuality should come under some influence that shall carry it off from its self-centred "Liberty," and occupy it in an honourable unreserved spirit in work under what is greater and better than self; what I mean is, that as "free" individuals we have not power enough over ourself. I don't mean power to repress ourself—we can acquire that—but power to use ourself actively; a very different thing. How much of any man's wretched restlessness could be traced to the half-conscious striving of faculties he can't use. To use them he must go under some mind moved by greater purpose. A great enough purposer can use any man's waste powers—powers that are out of the man's own reach. But if he will remain in self-centred "Liberty," then that better social part of his nature which his self cannot move is lost to himself and to others. The best interpretation of human restlessness is the instinctive desire to be used for some strong purpose, some meaning greater than a man's own individual tendency.

In another aspect you will see that the power of Prayer is of the same kind. For this waste of which I speak can be got hold of and used strongly by spiritual conviction, as well as by the influence of other minds. Here, perhaps, is the greatest prospect of a fruitful economy. The great store for the future to develope. Saving waste is always a worthy object. One ought to be ashamed of waste. It shows one's mechanism is not so good as one's luck.

PILOCEREUS SENILIS.

THE Great Northern Hospital is about to discontinue its out-patient department.

MR. MUDIE is about to establish a Student's Library.

THE LATE DR. DICKSON.—We have to record once more the painfully sudden death of a metropolitan physician—Dr. Thompson Dickson, lecturer on mental diseases at Guy's Hospital, and known by various contributions to medical literature bearing upon diseases of the nervous system. Dr. Dickson was a comparatively young man, little over thirty years of age; but for some years his friends have been aware that he suffered from serious mitral disease. He was, however, apparently in more than usually good health prior to Monday last. He was reading in his carriage, returning from a visit to a patient, when his wife, who was with him, observed that he bent forward, and remained in that position, as though looking for something on the floor. He returned no answer on being interrogated; and on being raised, proved to be dead. Dr. Dickson, whose career has been ended with suddenness so impressive and so distressing, was a laborious and anxious worker in the field of psychology. He was a graduate of Cambridge; and his connection with Guy's Hospital would probably have brought him sooner or later into greater prominence than he held at the time of his death. He was an occasional contributer to our columns, and the author, among other articles, of one which greatly stirred the passions of his brethern; it was entitled "A Social Blot," and has, we believe, frequently been attributed in error to various other pens.—*British Medical Journal,*

(*From the Medical Press and Circular.*)

THE LATE MR. WORMALD.—Another St. Bartholomew's veteran has passed away, and one, too, who had the faculty of attaching to himself warm friends and admirers. Thomas Wormald is no more, having died at the age of 71 years, at Gomersail, Yorkshire, on the 28th ult. He had retired from London practice, in which, during a long and honourable career, he had filled the highest posts a surgeon can occupy. He was President of the Royal College of Surgeons of England in 1865, and was at the time of his death consulting surgeon to St. Bartholomew's Hospital, to which he had previously been surgeon and assistant-surgeon. His was a remarkable instance of the length of time a man may be called assistant-surgeon, in consequence of no vacancies occurring to secure promotion.

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IT has been ascertained that during the past year £80,000, in donations of £1,000 each, have been given to the various metropolitan charities anonymously, and in nearly every instance it is thought that this disinterested work of charitable munificence has been by one and the same individual. There has also been one anonymous donation of £5,000, and probably nearly a quarter of a million in smaller sums.

WOMEN DENTISTS IN EGYPT.—The *Philadelphia Reporter* publishes a note from a medical man who writes from Cairo, in Egypt to a friend in Baltimore, that there is "a good opportunity women for dentists in Egypt, as in the East women are forbidden to consult with men." There are three or four English women practising dentistry in Cairo already, according to the letter.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

ANSWERS TO CORRESPONDENTS.

W. H. D.—We really cannot notice unahthenticated communications.

O. N.—The Index for Vol. II. is being prepared, and will soon be ready.

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Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

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Guy's Hospital Gazette.

VOL. III.—NO. 16. SATURDAY, JANUARY 17, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

Now that half the session has passed, and already seven papers have been read before the Physical Society, it is time to enquire whether the third and fourth year's men have realized the expectations we expressed at the commencement of the session. Our readers will remember, that from their numbers we anticipated much. Let us see what they have done. These are the papers that have been read—"Retention of Urine," Mr. Lubbock; "Hydrophobia," Mr. Williams; "Congenital Syphilis," Mr. Cock; "What relation does Tubercle bear to Phthisis?" Mr. Paul; "Germs—their history and connection with disease," Mr. Utting; "The Turkish Bath—its prophylactic and therapeutic properties," Mr. Giblin; and "Vaccination," Mr. C. Rees. Three out of these seven have been simply stop-gaps, papers read by senior men, who are of course excluded from competition, and each one of them bears evidence of a lack of energy amongst the junior members of the Society, which we have regretted much to observe; when there were so many of those qualified to compete, who were well calculated to write papers worthy of the Society, which has the right to expect their support. The authors of the remaining four are to be congratulated upon their enterprising spirit, since such a spirit seems to be the exception rather than the rule; but it is to be hoped, that amongst at least a hundred who are able to compete, a few more such exceptions may be found for the remaining half of the session.

Turning to the debates, we are pleased to be able to report more favourably. Those unpleasant pauses, which we remember were rather frequent a few years ago, have almost entirely disappeared now. The speakers are more in number, they keep closer to the subject under discussion, and seem more generally to understand that there is no cause for uneasiness in getting up to express their opinions before their fellow-students. On the whole the debates have been decidedly successful this session; indeed, we remember only one blot on their history, and that occurred at the last meeting, when one of the members took upon himself to indulge in a personality, which he may be assured was a mistake he had done better to avoid.

At the next meeting Mr. E. O. Day will read a paper on "Electricity," a subject of much general interest in medicine, and calculated to call forth a good discussion.

LECTURES ON MEDICINE.

TYPHOID OR ENTERIC FEVER.

BY DR. WILKS.

(*Continued from page* 116.)

In typhoid fever the most characteristic symptoms have reference to the peculiar changes in the intestines, therefore it may be as well to describe first of all the process which takes place in them. It is thought that the typhoid virus, after entering the system produces therein certain changes of a fermentative kind, and that the poison having propagated itself in the system to an almost indefinite extent is carried off by the intestinal glands. The incubative period, as well as the whole duration of the disease, is much longer than in the exanthemata, and it is probable that almost from the very time at which the poison enters the body the intestinal glands begin to be affected. These glands are Peyer's and the solitary glands. You know that the former are aggregated in long oval patches, larger and more numerous towards the end of the ileum, smaller and rounder higher up the canal. The spots seen upon them consist of circles of black specks corresponding to the mouths of the follicles in the submucous tissue. The solitary glands are of the same composition, and are scattered amongst the Peyer's patches, and are also found in the cœcum and large intestine. These two sets of glands, at a very early period of enteric fever, are observed to be enlarged and swollen, and, as the disease progresses, become occupied by masses of

working-man whom we admit into hospital he has often not taken to his bed when he appears on the eighth or tenth day of his illness. It is said, however, by some observers the soft typhoid material. It is not often that we have an opportunity of seeing the intestines when the process is at its height, but from specimens in our museum this appears to be from the tenth to the twelfth day of the fever, reckoning from the day on which the patient is taken ill. It is still a question as to the exact nature and seat of the deposit. When examined by the microscope it is seen to be composed of cells with several nuclei, but presenting no very characteristic appearance, although they are believed to have a definite and distinctive character of their own. It is also a question whether the new material is deposited within the flask-shaped follicles or glands or in the intervening tissue. The former opinion is held by many because it can be often shown that after recovery from the disease the Peyer's glands have resumed their normal appearance, and that when an evident destruction of surrounding tissues has taken place an unusual and abnormal extension of the deposit has occurred. The nature of the pathological process is the formation or growth of a peculiar deposit, and a subsequent disintegration of the same. The process, remember, is not an ulcerative one, although an ulcer may subsequently form; you must not, therefore, regard the affection as a simple inflammatory one ending in ulceration. In the first place a deposit of a peculiar nature is formed within Peyer's and the solitary glands when some increased vascularity may be observed around. This material disintegrates, a part of it being absorbed and a part thrown off, either in form of small particles in shreds or in complete casts of the oval patches. Or it may be considered that the gland follicles become filled with this new material, and that they then burst and then throw off their contents. I told you that the affection would reach its height in twelve to fourteen days, and if death occurred at this period you would see these masses of deposit rising above the surface of the mucous membrane, and if two or three met they would nearly close the intestine. After this time they soften and disintegrate, so that if seen during the following few days the surface of the gland appears rough and shaggy; they then become still smaller, so that at the usual time of death after the third week, Peyer's patches have a rough appearance from portions of the material being still adherent. The solitary glands also present ragged points about the size of peas. If the tissue intervening between the follicles is involved then the sloughing process may attack the mucous membrane, the submucous tissue, and all the other structures of the intestine. If sloughing is very active a blood-vessel may be opened, or the muscular and peritoneal coats may slough and a fatal perforation ensue. Or, superadded to the sloughing process, an inflammatory and ulcerative action may take place when a true ulcer may form, which must cicatrise before a cure is complete. It is possible that the true typhoid process which occurs in the glands is little more than what I have mentioned, but if the neighbouring extra glandular structure become involved then the various stages of inflammation ensue before cicatrisation is comple e.

We will, now, once more commence at the beginning, and suppose that the patient has received into his system the infecting virus or germ. This is slowly producing a change within the body, and probably in a visible manner on the intestine for twelve or fourteen days before he begins to feel ill. The patient often thinks he has taken cold, as he experiences a general malaise with pains in the limbs and other feverish symptoms. During the next few days the patient becomes still more feverish and ill, and as regards the that fever heat is reached on the fourth day; but it is admitted by all that the symptoms approach much more slowly than in typhus, and are much less severe, there being less prostration, less severe headache, &c. Although the symptoms are those which are common to all febrile disorders there may be a suspicion of the nature of the impending malady by an early tendency to diarrhœa, or sometimes by an epistaxis, which is a not very uncommon early symptom.

About the tenth day after illness, the characteristic rose rash makes its appearance. The spots are usually observed first on the chest and abdomen, appearing as small points of a pink colour—perhaps half a dozen in number—which in a few hours develope into the true rash. At the same time that these are forming, fresh spots are appearing, and so on from day to day. Each spot lasts four days, and then fades away. There are thus successive crops daily coming forth until the termination of the fever. There may be only ten or a dozen of these spots to be counted at one time, or they may be fifty or more. They may be also observed on the back and limbs. It is only in about four fifths of all the cases of typhoid fever that we meet with them. The designation of Louis, who first described them, will best pourtray their character —"tâche rose lenticulaire," the first word implying a spot which fades on pressure, the second carries its meaning with it, and the third implies a spot which is circular and raised like a lens or watch-glass. It is, therefore, rounded, to be felt by the finger and not acuminated.

If, then, the patient be seen at the height of the disorder, he will be in bed, very ill with all the usual febrile symptoms, but the following points may be specially noted:—First, owing to the chief seat of the disease being in the intestines the main symptoms have reference thereto; thus the abdomen is full and doughy owing to the bowels being distended, and on feeling them a gurgling may sometimes be heard from their contents being composed of air and fluid. There is diarrhœa, the bowels being relieved two or three times a day, the motions being liquid and yellow, or rather as if solid fœcal matter had been powdered up in a liquid, they are thus technically called "ochry," and are said to be like badly made pea-soup. If carefully examined, sloughs of typhoid matter may sometimes be found, and they are said to be rich in saline matters, and occasionally blood may be observed to be mixed with the stools. The patient is, as a rule, not so depressed as in typhus fever, and may often be observed to have a flush on one cheek; the tongue is very characteristic, the fur having gone, it is left red or beefy, at the some time very dry, glazed on the surface, and often fissured, so that it bleeds when protruded. The pulse is 120-130. The temperature undergoes a remarkable daily rise and fall, and the same occurs at the onset of the disease, so that it has been said that a sure diagnosis can be made from this sign alone. It is generally said that the temperature falls one degree every morning, and rises again every night, but in several accurate reports taken here the extreme rise was found about four o'clock in the afternoon and then the fall began. Again, it has not been found by all observers that fever heat was reached on the fourth day, but is it more difficult to obtain exact experiments in respect to this. I will give the table of Wunderlich, which you may keep by you for the sake of comparison with any observations of your own:—

	MORNING.	EVENING.
1st day ...	98·6 ...	101·3
2nd day ...	100·22 ...	102·55
3rd day ...	101·06 ...	103·64
4th day ...	102·56 ...	104·44

You will see by this that the rise and fall of temperature exists from the very beginning of the disease, and which marks a peculiarity about it. The lungs are frequently much congested in typhoid fever, and therefore a cough with expectoration of a bloody mucous sputum is not uncommon. There is sometimes sickness, and the urine as in other febrile diseases. If hæmorrhage occurs from the bowels, it is not to be considered necessarily of grave importance.

The patient thus lies until three weeks have elapsed, when there may be a daily expectation of his recovery. The tongue becomes moist, pulse less frequent, diarrhœa ceases and no fresh spots appear; and temperature again subsides as it rose.

If the patient do not recover, all the bad symptoms which I described to you in typhus become apparent, the patient lies prostrate on his back, tongue very dry, mouth covered with sordes, delirious or muttering, pulse 104 or more, retention of urine, abdomen much distended and tympanitic. Breathing more quick showing increasing congestion of the lungs, a general livity of the extremities, but no petechial change of the rose spots. Death may occur from simple prostration, but there is generally some more special cause for dissolution, thus, the diarrhœa may be excessive or the hæmorrhage may be in large quantities and so prove fatal, or a perforation of the intestine may take place. In other cases a pneumonia is added to the congestion of the lungs, and thus death may ensue. When perforation occurs, it may be suspected, if the patient have not previously been ill by his becoming collapsed with distension of the abdomen. In bad cases, however, the diagnosis is by no means easy for, owing to the existing extreme prostration of the patient, the lowered state of the pulse or increased tympanitic state of the belly may not be discernible, and on the other hand, from this increased distension and lowering of pulse being the concomitants of the typhoid condition, a perforation is sometimes suspected when it has not occurred.

(*To be continued.*)

PHYSICAL SOCIETY.

The seventh meeting during this session of the above society took place last Saturday evening, when Mr. H. Hetley occupied the chair, and Mr. C. Rees read a paper on "Vaccination," of which the following is an abstract:—

He commenced with a short history of vaccination, and an account of the phenomena which take place when it is done with lymph from the human subject, in comparison with those that occur when it done with lymph from the cow. He then proceeded to discuss the relation of vaccinia to variola, and came to the conclusion that they were identical, quoting several experiments which he considered proved this. He then went on to state, that, in his opinion, vaccination was not now a preventative to small-pox, although it tended to prevent a fatal result, and he considered that this loss of preventative power was owing to a degeneration of the lymph, caused by its being so thoroughly humanised. He then proceeded to discuss the capability of vaccination setting up or conveying other diseases into the systems of people vaccinated, stating his belief that it could do both, and giving one or two cases in which eczema and excessive anæmia followed that operation. He thought that vaccination, by rendering the blood in a diseased condition, would favour the production of tubercle; and, if tubercle were capable of being inoculated, it might be introduced into the system by vaccination. He considered it proved beyond doubt that syphilis might be introduced into the system by vaccination. In conclusion, he advocated a renewal of the present stock of lymph by the practice of retro-vaccination, and that a thorough investigation into the family history ought to be made before using a child as a vaccinifer. All those who had any history of phthisis or syphilis ought to be rejected as such.

Mr. Giblin, in commencing the discussion, thought that too much respect could not be paid to the memory of Jenner, when they considered how many thousands of lives were annually saved by his perseverance and ingenuity. Arm to arm vaccination had the advantages of being easy, cheap, convenient, though by it such a disease as syphilis was often transferred. He was of opinion that by using the lymph only and no blood with it, syphilis would not be conveyed from one to another, and thought that the lymph which had become deteriorated by passing through so many constitutions should be renovated by vaccinating from a healthy heifer. As to the people who objected to have their children vaccinated, he considered they had as little sense as an old gentleman, whose son reproved him for so constantly standing on his head—

"In my youth," father William replied to his son.
"I thought I might injure my brain,
But now that I'm perf ctly sure I have none,
Why I do it again and again."

Mr. Harsant thought some of Mr. Rees' opinions were rather startling. In reference to the diseases he had suggested might be produced by vaccination, he (Mr. Harsant) thought, that the cases alluded to tended to show that they were *post hoc*, not *propter hoc*; for instance, the case of eczema. What was more common in children? And Mr. Rees had given no proof that the case of epilepsy was produced by vaccination. Syphilis was undoubtedly carried, but he believed only by the blood. Mr. Rees had expressed his opinion, that the vaccine should be more frequently taken from the cow. Five or six years ago Mr. Marston had a cow in his room, which had been inoculated from another cow; from this cow he then vaccinated a number of children, and has ever since vaccinated from the same source with perfectly satisfactory results.

Mr. Palmer considered the subject of the paper was one of great interest, and calculated to be understood by all. He believed the eczematous state was often produced amongst the poor by carelessness and dirt. He depreciated the practice of not changing the source often enough. He thought, that of the various modes of preserving the lymph, the capillary tubes was the best, and gave some precautions for successfully sealing the tubes.

Mr. Day mentioned some statistics, which had been quoted in the *British Medical Journal*, greatly in favour of vaccination. According to the same journal, it seemed almost impossible to get death from small-pox in a case where three good vaccine vesicles had been produced. Speaking of the transmission of diseases, he could not see at all how tubercle could be carried with vaccine, while it appeared to him rational that syphilis should be so carried. Mr. Day then gave some remarks of Ricord's bearing upon spyhilis.

Mr. Fry spoke of the number of vesicles required. It seemed to him that the inoculation would be as complete with one as with three. He thought that when tubercle or

syphilis occurred after vaccination, it was due to the admixture of blood with the lymph. He spoke of the active principle of the lymph, and would like to know how long the protection of vaccination lasted.

Mr. Tyson made some observations upon the practice of a doctor, who kept a cow for vaccine.

Mr. Cock said that Mr. Day and Mr. Fry appeared to think that the more vesicles the greater the protection, he did not agree with them. It was the same as in syphilis—four chancres were no worse than one. He believed that no one was insusceptible, if properly vaccinated. Cow-pox was a rare disease; he had seen thousands of cows without once meeting with it. He was of opinion that syphilis, appearing after vaccination, was usually of congenital origin.

Mr. Day explained that Mr. Cock had misunderstood him.

Mr. Chicken thought that we had wandered from the subject in speaking of syphilis, but added some further remarks upon this disease, in reference to some that had gone before. He could not agree with Mr. Rees, that vaccinia and variola are the same disease, nor with his recommendation—to vaccinate directly from the cow, for, he believed that, under these circumstances there being a greater amount of inflammation produced, simple exudation cells would be mixed with the lymph, and that, if the child vaccinated were syphilitic, these cells would be capable of carrying that disease. He recommended that statistics should not be trusted. And, speaking of the phenomena observed in connection with vaccination, pointed out that, as in the fevers, the symptoms might produce secondary results.

Mr. Bevan said that since it was shown that vaccine degenerated as it passed through generations of men, he thought it probable that it became tainted with other diseases, and so they were carried with it. He pointed out that eczema might follow any simple abrasion under certain circumstances. He did not think that tubercle could be carried with vaccine.

Mr. Lamb saw no reason why we should produce a more severe form of vaccinia, by vaccinating directly from the cow, when the present method from arm to arm sufficed for at least several years, and could be repeated. Re-vaccination was not performed as often as it might be; for, in the Army and Navy, where it was repeated at regular intervals, small-pox seldom occurred, and at some stations was unknown. He thought statistics showed that scrofula and phthisis were not produced by vaccination, as they had decreased since its introduction.

Mr. Gathergood would like to know how it could be told whether a child were tuberculous. In reference to Mr. Cock's remarks, he had seen cases of insusceptibility to vaccination.

Mr. Justin M'Carthy remarked that amongst the poor, where a number of children are vaccinated together, blood is likely to be carried on the lancet.

Mr. Stevenson had a strong desire that the *Guy's Hospital Gazette* should not propagate the idea that tubercle could be carried by vaccination, without recording at the same time, that this was not the case in his opinion.

Mr. Shadwell mentioned the value of injecting vaccine in variola, and narrated a case in which the vaccine conquered. He did not think vaccinia and variola to be the same disease. And, though he could not prove it, he believed that vaccination might cause phthisis.

The chairman then called upon Mr. Rees to answer the discussion, after which a vote of thanks was given to him for his paper on "Vaccination."

MEDICAL WARDS.

—o—

The following cases were admitted from Jan. 8 to Jan. 14, 1874.

JOHN (Clinical).

10—Heart Disease—Aorta
16—Disease of Temporal Bone

MIRIAM (Clinical).

21—Hysteria
32—Immersion

PHILIP

3—Bronchitis—Emphysema
9—Rheumatism
13—Bright's Disease
24—Convulsions
25—Lead Palsy
28—Bronchitis—Emphysema
37—General Atrophy

STEPHEN

4—Sequelæ of Ague
7—Left *Hemiplegia*
10—Phthisis
11—Bronchitis
13—Heart Disease—Aorta
20—Heart Disease—Aorta—Pneumonia
28—Acute Rheumatism
31—Pleurisy
36—Heart Disease—Aorta

MARY.

18—Anæmia
20—Pleurisy

ADDISON.

4—Laryngitis (Subacute Catarrhal)
7—Eczema Capitis, etc.
11—Facial Erysipelas
21—Chorea
26—Rheumatism
40—Peritonitis

ASTLEY COOPER

7—Rheumatism
9—Morbus Cordis
13—Chlorosis
14—Chlorosis
23—Hysteria

SURGICAL WARDS.

—o—

The following cases were admitted from Jan. 8 to Jan. 14, 1874.

LAZARUS.

6—Hæmorrhoids
9—Necrosis of Metatarsus
15—Stricture

ACCIDENT.

2—Concussion
10—Fractured Tibia
12—Contusion of Back
16—Fracture of Femur
21—Punctured Wound near Knee-joint
29—Fracture of Femur

CORNELIUS.

7—Fracture of Tibia and Fibula

LYDIA

7—Contusion of Foot
9—Intestinal Obstruction—Cancer—Death
18—Contusions
18½-Fracture of Tibia and Fibula
20—Club Foot
23—Contusion of Leg
24—Abscess about Knee-joint

MARTHA

6—Tumour of Breast

NAAMAN.

5—Ulcer on Leg
6—Epithelioma of Lip
7—Stricture
8—Caries of Metatarsus

JOB.

4—Vesical
9—Stricture
10—Stricture
14—Dislocation of Elbow
15—Dislocation of Knee
19—Old Disease of Femur
21—Swelling (Inflammatory) in Groin

LUKE

1—Inflammatory Swelling in Calf
14—Old Disease of Knee-joint

DORCAS

1—Contraction of Ankle-joint after Puerperal Pyæmia
3—Necrosis of Humerous
21—Poisoned Thumb
19—Enlarged Glands in Subclavian Region

CHARITY.

4—Ulcers on Leg
8—Abscess on Chest and in Left Axilla

RUTH (Ophthalmic).

33—Corneo-iritis
41—Cataract
46—Closed Pupil

BARNABAS (Ophthalmic).

3—Cataract in left Iris
5—Accident to left Eye
6—Glaucoma both Eyes
11—Perforating Wound
12—Cataract across Cornea
16—Closed Pupil
23—Cataract
24—Glaucoma

FOOTBALL CLUB.

GUY'S I. v. BLACKHEATH.

Last Saturday the return match took place on the grounds of the latter, and as usual excited great interest. It will be remembered that the first match which was played before Christmas was won by Blackheath, but on that occasion we were deprived of the services of our captain and also of Maclean and Rendall, all of whom were announced to play last Saturday, although to the great disappointment of every one Maclean did not return in time to play, and Gilbert also being absent, we were not so strong as we expected to be.

Blackheath having won the toss chose the lowest goal and played with the wind for the first half time. The ball was kicked off by Gray, but was soon returned into dangerous proximity with the Guy's goal, and although our forwards worked hard and gradually worked the ball towards the centre again, it was soon driven back by some fine drop kicks from L. Stokes, who played back for Blackheath. This was repeated again and again; no sooner did the Guy's forwards work the ball a short distance from the goal, than the Blackheath backs dropped it back again, and before 20 minutes had elapsed they had compelled us to touch down twice in self-defence Just before half-time one of the Blackheath men made his mark, and had a free kick at goal, but the ball was stopped by some of our forwards and nothing resulted.

After changing ends the state of affairs was completely changed, for the Guy's forwards slowly and steadily forced the ball towards the Blackheath goal; it was now evident that, although our opponents were very strong behind the scrimmages, yet our forwards were much the better, accordingly Pinching made it as much as possible a game of forwards for the rest of the time, and during the last half hour the Blackheath half-back, scarcely touched the ball, for no sooner had the Guy's forwards forced the ball through the scrimmages than it was closely followed up and held, and then the scrimmage immediately renewed; again and again did Robson who played magnificently, follow the ball closely up and carry it right through the Blackheath half-backs; Pinching also was quite up to his old form, we have not seen him play so well since he played in the English twenty two years ago. When the ball was just in front of the Blackheath goal Gray, who was playing half-back, having obtained the ball took his drop, but the ball unfortunately passed about a yard outside of the goal post,and the umpire gave it as no goal. After this nothing occurred, and the match which was very fast and hot throughout was left drawn. Power, who played three-quarters-back did very good service, several times collaring the Blackheath half-backs very effectually. A. W. Pearson (back) was good as usual. Breach scarcely got a chance, but was very useful occasionally.

Rendall and Mutch were especially noticeable among the forwards.

We were glad to notice that Blackheath did not adopt their usual objectionable plan of heeling the ball out of the scrimmages, but played up very straight and fairly.

The following formed the Guy's team:—Forwards—Pinching (captain), Robson, H. Duke, Welchman, Wells, Rendall, Mutch, Gibb and Collins; half-backs—Finch, Gray and Brown; three-quarters-back—Power; backs—Breach and Pearson.

OUR NOTE BOOK.

—o—

SYPHILIS IN THE LIVER.—In the liver two distinct syphilitic conditions may be found. (*a.*) Distinct Gummata. These are generally found P.M. in the bodies of those who have not been brought under the influence of potassium iodide. (*b*) This second condition may be met with during life, as in a case mentioned by Dr. Wilks. Here the syphilitic liver may reach to the crest of the ilium; under the use of potassium iodide the viscus may in time return to its natural size. The deposit is, in these cases, of a softer, more interstitial kind than in the first-mentioned class, where gummata are present.

PARAMETRITIS: ITS CAUSES.—(1.) Labour. This is the most common. As a rule it ensues in the first few days, but it may delay its appearance for three or four weeks, whereas (and this is an important diagnostic point) Perimetritis, if it occur at all, does so in the first nine or ten days. (2.) Injuries. *e.g.* Division of the cervix, and the introducton of uterine stems. (3.) Gonorrhœa. This is often a cause by matting together tissues such as those of the fallopian fimbriæ, the inflammation having reached those parts by extending over the cavity of the uterus and the fallopian tubes. (4.) Growths. *e.g.* Cancer and Tubercle. This last generally starts from the fallopian tubes. (5.) Causes connected with Menstruation. The following may be considered a typical case:—The wife of a clergyman, during a menstrual epoch, gets very wet at a village school-feast; the menstrual flow stopped and violent pelvic pains came on as suddenly, and after three or four weeks' illness pus discharged itself plentifully from the rectum. Both varieties may exist without much pain if of gradual occurrence. Cases in point are those due to gonorrhœa and those due to some ovarian tumours, which bring about great adhesions and yet attract but little notice as far as pain is concerned.

"DARE QUAM ACCIPERE."

I wonder if Guy's motto has any reference to the physic given there. No doubt it is not so good to have to take *that* as it is to give it. If you have any doubt just taste a few bottles. (You will find them over the beds in the Wards.) When you have tasted five, or perhaps before, the question rises to your insulted tongue—Why are they made so execrably nasty? And you may ask whether the disadvantage of *accipere* might not be made to settle a little less bitterly on the recipient's palates.

But givers are so apt to forget that it is better to give than to receive. The receivers don't forget it. They know well enough that it is better to give. Think of this when next you are roused by ingratitude. In fact, the advantage you have in giving should be remembered in every gift so that you graciously recognise the receiver's disadvantage. By thus reversing the vulgar order of proceeding you will set up right relations between yourself and your humble recipient. For, if it is better to give, then the giver is the party really obliged in the transaction; and should give his gifts and arrange his expectations of gratitude accordingly. So obnoxious indeed is receiving that you will, with a little insight, easily see that few people ever receive in quite a passive way at all. Receivers so keenly know their disadvantage that they try to avoid passive receiving by all sorts of devices; nearly every one who gets a thing from you will have some way of setting it down to his own taking power. For example, that fuliginous, skilly-fed scoundrel who cringes for a penny and shuffles off with it sniffing, do you think he accepts passively? Not at all! He knows he is a taking person. He got himself up to draw your penny, and whatever you think, he knows he did it, and hopes he will be as successfully nasty with the next gentleman that comes along.

But if the receiver resents the relation he is in even when you part with commodities for his benefit, How will he rise against being made receiver when he gets nothing for it that he cares about? a hint, for a instance, or more pointed advice. Here receivers are apt to get angry. Yet they need not. They might see on their part that as the giver gives nothing, his blessedness is proportionally small; they needn't envy it. Especially those who give only gratuitous advice. You often meet such people. A sort of impostors who try to get the advantage of giving for nothing, People who themselves possess two great blessings—comfort and a good conscience. They would like to be blessed givers to you; and in their wish would hand you over something as a gift. The joke is they then show you how much more readily they will share with you their good conscience than their comforts.

But I forgot about the physic, which really might be made nicer.

PILOCEREUS SENILIS.

ROYAL COLLEGE OF SURGEONS.—The following gentlemen have recently passed their primary examination for the Membership:—Messrs. T. Bell, Hall, Porter, W. Kidd, T. Fell, Boughton, L. H. Stevenson, J. L. Lewis.

MEDICAL MICROSCOPICAL SOCIETY.—The anniversary meeting will be held on Friday next, at 8 p.m.

A RACE OF DWARFS.—The Geographical Society of Italy has received from Alexandria, with the news of the death of the explorer Miani, and various ethnological objects, two living individuals whom he had forwarded of the tribes of the Akka or Tikku-Tikki, and whom the learned traveller had bought of the King Munza. These individuals—of whom one is eighteen years old, and forty inches in height, and the other sixteen and thirty-one inches high—are stated by Miani to belong to the race of dwarfs described by Herodotus, and recently rediscovered by the German explorer Schweinfurth, who described them carefully. They are pot-bellied, very thin-limbed, and knock-kneed, spherical and prognathous crania, very long limbs, copper skins, and crisp, tow-like hair.—*Medical Record.*

A COMPETITIVE examination of candidates for admission into the medical service of the Royal Navy will take place at the University of London on Monday, Febuary 16th, and following days.

PREHISTORIC MAN.—A number of diseased bones (tibia, fibula, &c.), found in the mounds of Middle Tennessee, point unmistakably to the existence among the aborigines of constitutional syphilis.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

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Guy's

Hospital Gazette.

VOL. III.—NO. 17. SATURDAY, JANUARY 24, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

AMONGST the number of ideas in which the true order of things is commonly reversed, is that which supposes, that one man studies because he is clever, and another does not because he is a fool. The popular notion of the development of the mind is something after Topsy's vague "S'pose I growed"; and simpering fops with their vacant expressionless countenances sooth themselves, when a knowledge of their ignorance is forced upon them, with the excuse that Nature has not *endowed* them with a great mind. Poor fellows! Yet perhaps it is not altogether their fault that they passively waited to "grow" clever; for, even in these enlightened times, it is an universal idea, that a healthy mind can be built up from dry classical and commercial detail. A man feels accountable to himself for the strength of his muscles, the truth of his vision, or the accuracy of his ear. He does not expect to grow strong at a desk, to become a great artist if buried in a city, or a great musician if engaged in an iron foundry. An association between all organs and their functions is appreciated, except between the brain and the mind. The athlete exercises his muscles, the artist surrounds himself with the beauties of nature, the musician with sounds of harmony; but the school boy, whose mind is to be developed, is cut off from the grand lessions of Nature, and taught to think from a study of the requirements of modern society. Indeed, it often happens, that not until the student of medicine has commenced his course of study at a medical school, does he have the opportunity to gain a knowledge of other things in the great creation, than those which proceed from man. He is taught the duplicity of his fellows, and learns how to be even with them. The objects of his education are, that he may know the value of money, and pass in society for a well-educated gentleman, which means that he is a moderate English scholar, that he knows something of French and German and Classics, that he can dance, "talk politics," and the like. But his knowledge is limited to such as this. His conception of truth and beauty is based upon a study of the works of man, rather than of the works of GOD; and it is no wonder, that his mind is often false and narrow and void of noble principles. The value of studies such as Natural Philosophy, Comparative Anatomy, Physiology, Histology, &c., cannot be too highly estimated, for it is impossible to pursue them without gaining some habit of thought. Even the blank face of the man of fashion, the empty stare of an empty life, when brought under such healthy influences is led to assume an expression of reason. He who has been fed with the false laws of man since his birth, when brought face to face with the wonderful truths of Nature cannot fail to be attracted, cannot forbear to study them further. How can he learn of truth and still be false? If we would be true and noble, we must not take our standard from the the works of men; but we must enlarge our minds by a study of the infinite beauties of Nature. Never did the Council of the Royal College of Surgeons issue a wiser decree, than that all students should study the Microscope. Never did our teachers commit a greater error, than when they opposed and defeated Professor Huxley's endeavours to establish Comparative Anatomy as a necessary study for those, who, of all, should be men of Science—the Students of Medicine.

IT is our painful duty to have to record the sudden death of Dr. Phillips. On Wednesday evening he retired to rest, feeling somewhat unwell, and was found on Thursday morning in an unconscious state, in which he

remained until three o'clock, when he died. We hope to be able to give our readers a fuller notice of this sad event in our next issue.

LECTURES ON MEDICINE.

TYPHOID OR ENTERIC FEVER, (*Continued*).

BY DR. WILKS.

(*Continued from page* 123)

On post-mortem examination of a fatal case of typhoid fever various morbid appearances may be found. There will be the characteristic changes in the ileum, as I have already described, the amount of deposit remaining in the glands varies with the time of death. At the usual period of death—between the third and fourth week—the Peyer's patches will be found having the rough and shaggy appearances before-mentioned, with slough and fœcal matter attached. In other cases portions of the mucous membrane will have been destroyed, and veritable ulcers may be said to exist. If there has been fatal hæmorrhage the glandular patches will be seen to have undergone a more active sloughing and perhaps an open blood-vessel may be found. If perforation has taken place, the mucous and muscular coats will be seen to have been involved in the sloughing process and the peritoneal coat perforated. Sometimes there is a good sized rent, at other times a large surface of peritoneum is laid bare within, and perforation has occurred by a number of minute pinhole points. These are seen best on the external surface, and here also is generally found some lymph or as much inflammatory exudation as could be produced in the few hours of life after the rupture of the gut. Associated with the intestinal disease is a considerable enlargement of the mesenteric glands which are observed to be swollen and soft, so that they readily break down on pressure. The new material which forms in their interior is considered by some to be of a specific nature, resembling the typhoid matter in the intestinal glands. The spleen, as a rule, is two or three times its natural size. The lungs are congested at their posterior parts, and sometimes associated with the congestion is an actual inflammation, so that the back part of the lung, and that towards the root is found consolidated from a combination of these two conditions. Occasionally another organ is affected—the larynx; at the posterior part of the vocal cords, at the root of the arytenoid cartilages a brown soft deposit is met with which exactly resembles the typhoid deposit in the intestine. This sloughs out, and in some cases has led to perforation, or has been the origin of a chronic disease of the larynx.

The Prognosis in typhoid is not as in typhus, according to the age of the patient, which, in other words, means in relation to his strength; for death occurs in typhoid from local or accidental causes, as hæmorrhage, perforation, &c., and the risks seem to have to do more with the virulence of the disease than the condition of the patient.

Varieties.—The varieties of typhoid may be best remembered as of three kinds. There is the natural division into the *mild* and the *grave*. You may have one patient, for example, who has clearly all the symptoms of the disease upon him, and yet at the same time is never very ill, and passes through the complaint without a single urgent symptom; then, on the other hand, there is the patient who from the beginning is excessively ill, so that you watch the case throughout with the greatest anxiety. Then there is a third class of case which comes under neither category, where the patient has few symptoms or none at all, and yet the typhoid changes are going on in the intestine which may end in death. This *insidious and latent* form has been called by German writers, *typhus ambulatorius*. (I might here warn you not to mistake the meaning of the word typhus when you read of it in foreign books. Both the French and Germans mean our "Typhoid or Enteric Fever" when they speak of typhus. They have little of our true typhus, which they call the English disease or exanthemic typhus; as, however, they often qualify the word by the epithet "Typhus Abdominalis" there can be no mistake.) In this latent form of typhoid the patient may be so slightly ill that the real nature of the disease has been never suspected, when a fatal hæmorrhage may come on or a sudden perforation of the intestine.

Relapse.—Another remarkable circumstance about typhoid fever is that a relapse may occur. After the patient has lost his fever, and been recovering during two or three days he again falls back into his original condition, in which the diarrhœa recurs, and a fresh crop of spots appear on the body. This second attack is of varied duration. If he should die it will be found that a second typhoid process has been taking place in the glands of the intestine.

Causes.—It is generally believed that typhoid is due to the taking into the system a specific germ or virus, and that this being reproduced in the body is thrown out again by the intestine. As intestinal discharges eventually make their way into the drains and sewers, so it is supposed that through these channels especially the disease is propagated. Either some article of food has been contaminated by water having an impure source or the patient has breathed into his lungs some floating germs which have arisen from some polluted water. All the evidence on the subject has hitherto tended to show that the disease extends in this manner. There is no reason to believe that any vaporous emanations from the body or lungs of a patient suffering from typhoid contain the poisonous element, and therefore typhoid is not contagious or infectious in the ordinary sense of these words. From the fact of the disease being associated with bad drainage, Dr. Murchison invented the word "pythogenic" as a substitute for typhoid, meaning "born of putridity," but as this might imply that any decomposing matter will produce the disease I dislike the term.

Diagnosis.—I have already told you a continuous febrile condition implies as a rule either the existence of a local disease, or a special virus working in the system. Now, as typhoid fever may sometimes occur without a rose rash or other very characteristic symptoms, you can easily see how it is that when neither local inflammation nor ordinary exanthemic disease can be discovered, a diagnosis in favour of typhoid is apt to be made. Thus it is that nearly every disease accompanied by fever is at times called typhoid. It is mostly due to carelessness, and therefore it would be a waste of time to tell you here how pneumonia, arachnitis or peritonitis differ from typhoid fever. When I come to speak of these diseases separately you will see in what their peculiarities consist. In the same way there is no very good reason why I should insist upon your endeavouring to distinguish typhoid from typhus. You are not likely to do so, for, as a matter of fact, typhoid is far more often mis-

taken for local inflammations than for typhus, but since the diseases were once confounded, it has become the fashion to treat of them together, to lecture upon them together, and to write upon them together. There is no reason in this, and it merely remains as a monument of our former ignorance. Why you as new men in the profession should be taught relatively to the shortcomings of your forefathers I don't know. As, however, you are constantly asked at examinations how to distinguish between typhus and typhoid, I will tabulate the main differences for you :—

	TYPHUS.	TYPHOID.
INCUBATION ..	Nine days	Twelve to fourteen days
ONSET ..	Sudden	Slow
DURATION ..	Two weeks	Three weeks or more
PREMONITORY FEVER ..	Three days	Nine days
ERUPTION ..	Mulberry	Rose
	Universal	Scattered
	Continuous	In successive crops
	May become petechial	Non petechial
BOWELS ..	Appears on fourth day	Appears on tenth day
	Abdomen natural form	Abdomen humid
	Stools dark	Stools ochry and characteristic
APPEARANCE ..	Torpor	Countenance more bright
TONGUE ..	More furred and brown	Flush on chest
CONTAGION ..	Highly contagious	Non-contagious
TEMPERATURE ..	Rapid uniform rise	Peculiar daily rise and fall
CAUSES ..	In connection with poverty and diet	In connection with defective drainage

Treatment.—The experience of all medical men coincides with what theory would teach: that in "a fever" much support is required. If it be true that a patient with fever is undergoing as much waste in twenty-four hours, as if the subject of it had been walking all day without food, you will see that a large amount of nourishment is required to compensate for the loss. Now, since the patient's stomach is not in a condition to digest solids, the substitute which contains all the elements of nutrition is milk, and this you will find is the best diet for most of your cases. My hospital patients have four pints of milk a day, and I find they are much better cared for than many private patients, whose stomachs are filled with beef-tea, arrowroot, jelly, brandy, wine, and a host of other messes. If the patient cannot digest milk, then substitute beef-tea for a part of it. There is such a thing as too much feeding done, especially in rich families, where, owing to the doctor having told the nurse that the case is one for food rather than physic, she thereupon "pours in" all the nourishment she can, overloads the stomach, which, unable to get rid of its contents becomes paralysed, the ganglionic nerves receive a shock, and the patient is restless and prostrate until he has vomited all he has taken, when the pulse rising he becomes calm and sleeps. This is a practical hint worth remembering—that a patient with an overloaded stomach is far more depressed than he is with a long-continued empty one. You need not give your patient stimulants as a matter of course. That alcohol tends to cure fever by antagonising any virus in the system is a mistake; in a large number of cases the average number of cures is higher without stimulants than with them. They are, however, of eminent service, and we judge of their necessity by the debility of the patient and can test their influence by looking for the subsidence of outward symptoms. A weak action of heart, very quick pulse, dry brown tongue, delirium and such symptoms suggest their use. We also use stimulating and tonic medicines. Ammonia is often good, sometimes quinine acts admirably as being instrumental in lowering the animal heat. If the diarrhœa be excessive we usually give an opiate enema, but it must be remembered that looseness of the bowels is a symptom of the disease, and cannot be checked by the administration of medicine. If much restlessness a mild opiate, such as *Dover's powder or opium enema.* If there be much hæmorrhage from the bowel the ordinary remedies are useful -as gallic acid and lead. If you should be called to a case—as I have been done—when an immense amount of blood has been passed and the patient is blanched and pulseless the best thing is to inject per rectum half an ounce of turpentine and repeat it. It acts as a stimulant, and being absorbed into the system tends to check the hæmorrhage.

(To be continued.)

MEDICAL WARDS.

—o—

The following cases were admitted from Jan. 15 to Jan. 21, 1874.

JOHN (Clinical).

13—Albuminuria—Ascites
16—Syphilis

MIRIAM (Clinical).

No Admission.

MARY.

6—Hysteria

STEPHEN

5—Chorea
12—Dyspepsia
19—Pericarditis—Enlarged Liver
20—Phthisis
29—Heart Disease—Asthma, etc.
30—Sciatica
33—Heart Disease—Mitral
48—Anæmia

ADDISON.

10—Incipient Phthisis
13—Tubercular Meningitis
Cot—Tumour of Abdomen—? Hydatid

PHILIP

4—Gout
5—Bright's Disease
9—Bright's Disease (Lardaceous)
10—Diarrhœa
22—Phthisis
30—Spinal Disease
33—Bronchitis and Chronic Phthisis
42—Heart Disease
43—Acute Rheumatism

ASTLEY COOPER

11—Carcinoma of Liver
17—Chlorosis
22—Incipient Bright's Disease
27 (cot)—Spinal Disease
26 (cot)—Acute Bronchitis

SURGICAL WARDS.

—o—

We have to thank Mr. Duran for the following report of a case of

WOUND OF THE RIGHT LUNG AND PNEUMO-THORAX.

W. C. æt. 30, was admitted into Cornelius Ward, November 8th, 1873, having been struck in the upper dorsal region of the spine with a crowbar, falling from a height of about 30ft. It was stated that the crowbar had to be pulled out of the wound. He complained of great pain and difficulty of breathing, and it was noticed that air passed through the wound with respiration. The accident happened at 3.15 p.m. He was put to bed as soon as he was brought in, and ordered Vin. Antim. 10 m. ex. mist., Ammon. Acet. 1 oz. every four hours, with iced milk to drink. Emphysema appeared on the right side. No breath sounds could be heard on that side, and it was tympanitic on percussion.

Nov. 9—Great dyspnœa, lips blue. He became so distressed for want of breath, that in the afternoon it was thought advisable to bleed him, accordingly 12 ozs. of blood were taken from his arm, and, though he did not feel so much relieved as was anticipated, still his temperature fell soon after, as is seen below. In the night some brandy was given with advantage. The right-side was now dull up to the mamma.

Nov. 10—From 2 a.m. to 7 a.m. his mind was wandering, he then expressed himself more comfortable, but died from suffocation at about 9.45 a.m. As he lay upon his back a quantity of fluid ran out of his chest though the wound.

Post-mortem—The right lung was completely collapsed, but not inflamed. There was a wound about 1½in. deep in its apex. Only one rib was fractured, and that was broken though its neck. The pleura costalis was torn away from the chest wall a good way, so that the crowbar appeared to have penetrated for about four or five inches. The left lung was healthy, as were all the other organs.

The patient had no hæmoptysis during life, and before bleeding he was quite flushed, though after it he became rather blanched.

	Pulse.	Resp.	Temp.
8th—5.20 p.m...	80 ...	32 ...	98·4
7.20 p.m...	104 ...	41 ...	99
9.35 p.m...	96 ...	38 ...	99·2
9th— .20 a.m...	106 ...	34 ...	100·6
10 a.m...	110 ...	40 ...	100·8
5.15 p.m...*	144 ...	68 ...	104·8
6.45 p.m...	144 ...	50 ...	100·8
10·45 p.m...	146 ...	54 ...	101.2
10th—2.0 a.m...	160 ...	60 ...	103·2
7.45 a.m...	156 ...	54 ...	103·2

* Venesection performed.

We have to thank Mr. Tyson for the following

NOTES OF A CASE OF CANCRUM ORIS.

L. J., æt. 6 years, was admitted into No. 7, Charity Ward, Oct 13, 1873.

The following history was given by mother:—Five months ago had gastric fever (?), two weeks later blood of a dull colour ran from right side of her mouth as she lay in bed, it continued to flow for twenty-four hours; quantity not known. After this she seemed to rally and was taken out of doors, but soon became sleepy and was put to bed again. On Tuesday, Oct. 7th, she had an attack of convulsions, in which the muscles of the face seem to have been chiefly involved; the attack lasted five hours. From Friday, the 10th, until the following Sunday she lost five teeth, three from the lower, and two from the upper jaw, on right side. When mouth was examined—Saturday or Sunday—it looked green around the gums (right side), and smelt offensively; there was also ulceration of the cheek on its inner surface, about an inch below, and a little posterior to side of mouth, and there appeared on the corresponding part of cheek, on its outer surface, a black spot, size of fourpenny piece, and around this the skin was green. In the course of the night (Saturday) a portion of the whole thickness of cheek, size of a florin, ulcerated through. The slough came away next morning, and from that time until now (13th) sloughing has rapidly extended.

On Admission—The whole of the lower lip, and part of cheek on right side, has come away. There is now a hollow cavity, large enough to admit a moderate sized orange. The space extends from symphysis for about 2in. towards left of jaw, and in a downward direction, as far as lower edge of inferior maxilla. Here the mental artery is withered up, and the bone is of a greyish colour. The upper lip is involved, and a large part of the cheek. The parts bounding space are in a sloughing condition, and inflammation extending some distance beyond edge of cavity. Face is much swollen, right eye being nearly closed. She is able to swallow both solids and liquids, but has no desire to take anything except water. Dozes much, cries on waking, and is perfectly sensible. To have Tr. Opii 4 m., Sp. Vin. Gallici 1 drm., Mist. Pot. Chlor. 2 drms., every two hours. The cavity stuffed with carbolic oil lint.

Oct. 15—Troublesome cough, vomited several times. Sloughing is extending in a backward and downward direction.

Oct. 16—A large portion of slough has come away, continues to spread chiefly backwards. Passes urine in bed.

Oct. 17—Spreading towards eye; a considerable portion of the upper jaw is now laid bare.

Oct. 21—The ulceration has now extended towards neck; the extremities are cold; takes less food.

Oct. 22—Face very pale. Temp. 101⅕.

Oct. 23—Temp. 100⅔, pulse 60. Brandy increased to 4oz. Submaxillary gland is now exposed, and part of zygomatic process.

Oct. 25—Temp. 98⅘, pulse 150. Bowels relieved in bed. Ulcsratian ceased to extend.

Oct. 27—Is quite sensible, and continues so to her death, 11 a.m.

P. M.—Broncho-pneumonia found in both lungs. Ulceration has reached some of the muscles of the tongue at post aspect.

The following cases were admitted from Jan. 15 to Jan. 21, 1874.

LAZARUS.

2—Old Fracture of Leg
5—Fungus of Testicle—Strumous
11—Sinuses in Groin
13—Fistula
19—Inflammatory hardening in Side

CORNELIUS.

1—Blood Effusion in Gluteal Region
2—Compound Fracture of Tibia and Fibula
9—Fracture of Tibia and Fibula
11—Injury to Chest—Hæmoptysis

LYDIA

9—Periostitis of Left Foot and Tibia
22—Disease of Hip-joint

CHARITY.

5—Ulcer on Back and Neck, specific?
8—Abscess in Axilla and on Chest
23—Lupus of Face

JOB.

6—Ulceration of Foot
10—Stricture
19—Urinary Fistula

LUKE

No Admission.

NAAMAN.

1—Abscess of Foot
5—Ulcer of Leg
6—Ruptured Popliteal Aneurism—Amputation—Transfusion—Death
6—Perinæal Section—Death
9—Abscess in Scrotum
10—Perinæal Section for Retention of Urine
11—Stricture
12—Abscess in Popliteal Space
20—Abscess in Groin

MARTHA

5—Tumour? in Breast
10½-Burns on Chest and Abdomen—Death
12—Contusion of Left Hip
21—Injury to Median Nerve—Painful Cicatrix
22—Abscess over Sacrum

ACCIDENT.

11—Lacerated Wound of Left Arm and Axilla
12—Acute Synovitis
12½-Con ussion and Scalp Wound
17—Injury to Chest
18—Acute Synovitis
22—Compound Fracture of Tibia and Fibula
24—Fracture of Fibula
31—Fracture of Tibia and Fibula

DORCAS

5—Fractured Femur
9—Cut Head
12—Varicose Veins, etc.
13—Necrosed Jaw
13½-Fractured Femur
18—Ulcerated Legs
20—Sinuses, etc.
21—Abscess over Pubes
22—Contused Head
22½-Carcinoma of Jaw
23—Ostitis of Hand

BARNABAS (Ophthalmic).

1—Corneitis. Both Eyes
6—Cataract, Right Eye
7—Opaque Capsule
8—Corneo Iritis
13—Wound of Cornea
17—Cataract
22—Granulations and Pannus
25—Closed Pupil, Left Eye

RUTH (Ophthalmic).

30—Opaque Cornea
32—Specific Corneitis
33—Corneo Iritis
39—Glaucoma, Both Eyes
40—Cataract
43—Iritis, Left Eye
45—Cyst, Left Eye Lid
47—Glaucoma, Both Eyes
48—Granulations and Pannus

OUR NOTE BOOK.

—o—

SUPPURATION of kidney is caused either by pyæmia or extension from the ureters.

THE symptoms of pyæmic abscess of the brain may be very slight for instance, in two cases all that was noticed was ptosis, squint, convulsions and death. At P M. the brain was in each case riddled with abscesses.

OF eight cases of diabetes, pneumonic phthisis was found in two, phthisis in two, acute pneumonia in one, acute ileitis in one (whilst under treatment by arsenic).

ANEURISM of a branch of the pulmonary artery bulging into a cavity is a very frequent origin of hæmoptysis in phthisis.

A FATAL acute bronchitis in a young previously healthy person usually means miliary tuberculosis.

ATHEROMATOUS vessels are the result of arteritis, not of a passive degeneration.

ENLARGED prostate is always due to myomata of the prostate, not to uniform enlargement. These tumours are analagous to fibroids of the uterus. The histological characters are alike in both.

FLATTENING of the convolutions may be due to—1. Much ventricular fluid. 2. A large apoplexy. 3. Tumour. 4. Inflammation.

Abscesses of great parenchymatous organs usually only give rise to very few symptoms or pain. since they are deep, and so no sensory nerves are involved.

In a tuberculous ulcer of the intestine the base is thick with tubercles on its peritoneal side. while the base of a typhoid ulcer is thin.

CHARACTERS of gouty kidney—1. Granular on surface. 2. Cortex wasted. 3. Pyramids of Ferrein obliterated. 4. Pyramids intact. 5. Gouty grains consisting of urate of soda (sometimes).

IN typhoid fever at P. M.. you find the brain hard and firm. Liver soft and clayey-looking. Spleen soft and pulpy. Kidneys in a state of catarrh. Intestine ulcerated.

FRACTURE of the spine always involves two or more vertebræ. The fracture is always downwards and forwards, never transverse. The temperature may rise as high as 109 deg. Fahr.

The opening in pneumo-thorax is most frequently about the middle of the upper lobe of the left lung on its lateral aspect.

Jaundice without pressure on ducts. 1. Acute suppression (yellow atrophy). 2. From mental emotion. 3. In acute fevers as pyæmic-puerperal fever, relapsing fever, typhus and malarious fevers. Jaundice may be divided into—(1) simple jaundice and (2) complicated. In 1 the patient is not much worse off than with a bad cold. When bile continues in the stools it is usually of the 2nd. form, for in catarrh of the ducts they become blocked up altogether, and no bile gets into the intestines; but in cirrhosis, tumour, or acute atrophy, the ducts are not wholly obstructed. In simple jaundice there is generally no pain, nor swelling of the liver. nor perceptible distension of the gall bladder; should it last more than three or four weeks, spasm from gall-stone should be suspected or a tumour. Virchow says that simple jaundice is due to swelling of the mucous membrane of the duodenum due to catarrh blocking up the opening of the bile-duct. Others ascribe it to a plug of mucous in the duct. Possibly both causes act together. Jaundice has been known to follow the administration of chloroform. Jaundice is rare in hepatic abscess.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following gentlemen were admitted members on Tuesday, January 21st.:—Messrs. O. Edwards, W. E. Paley and C. Duran. Mr. G. Snell passed in Surgery and will be admitted a member when qualified in Medicine.

On Wednesday, January 22nd:—Messrs. A. Hooper, L.S.A., Metcalf, L.S.A., and Saberton, L.S.A. Mr. A. M. French passed in Surgery and will be admitted a member when qualified in Medicine.

On Thursday, January 23rd:—Messrs. Whitaker, L.S.A., Bryan, L.S.A., J. W. Phillips, Wiggan, Maudsley, Gard, L.S.A. and Churchward, L.S.A. Mr. Tipple passed in Surgery and will be admitted a member when qualified in Medicine.

Diploma of Member.

Examination on the Principles and Practice of Medicine.

January, 17, 1874.

From 1.50 to 3 o'clock p.m.

1. A person is suddenly seized with severe pains in the abdomen, sickness and vomiting followed by prostration of strength; what are the various causes upon which the symptoms may depend? How would you distinguish them? And what treatment would you employ in such cases?

2. What is meant by Hemiplegia, Paraplegia, and Locomotor Ataxy? Describe the symptoms of each disease, and the morbid conditions upon which they depend.

3. Mention the different remedies which may be used to check Diarrhœa, and to allay sickness and vomiting, giving the doses and forms in which they are employed.

Write a prescription for the administration of such a remedy.

Examination on Surgical Anatomy and the principles and practice of Surgery.

January 16, 1874.

From 1 to 4 p.m.

1. Describe the method of Reparation in Simple Fracture of Bone, in Laceration of Muscle, in Division of Tendon and in Sloughing of Skin.

2. Mention all the symptoms of Concussion of the Brain, and give an explanation of them.

3. Describe the Diseases of the Skin usually grouped under the term vesicular; and give their appropriate treatment.

4. Describe the varieties of Primary Venereal Sores commonly met with, their probable consequences, and proper treatment.

5. Describe the affections known as Phymosis and Paraphymosis; explain their causes and possible consequences, and state their treatment.

9. What is Staphyloma? Mention its causes, pathology, and treatment.

FOOTBALL CLUB.

GUY'S II. v. GRAVESEND.

This match was played last Saturday at Gravesend, and after a very exciting game ended in favour of Gravesend, who obtained a goal against a touchdown. For Guy's all played up well; but Mallard. Kerr and Bain especially deserve notice. The following played fer Guy's:—Maltby (captain); Poland and Jackson (half-backs); Smart, Mallard, Johnson, Kerr, James, Mainwaring, Roberts, Richards, Reader, C. Perry, Perry, Bain and Dunlop.

GUY'S I. v. LONDON.

Our return match with London, which was played at Victoria Park last Saturday, we won easily by four goals and six touchdowns to one touchdown. We won the toss, so London kicked off, and after a few minutes' play, our adversaries, by a good rush, took the ball up to our goal, and Power was obliged to touch it down. This was the only point they scored throughout the match. Before half-time Robson secured a try, from which Gray kicked a goal. Gray also having made his mark, had a free kick, but the ball passed to one side. After halftime, we

pressed our adversaries more than ever, Finch by a very good run, landing the ball behind their goal, and Gray was again successful in his place; the London goal had also twice to succumb from drops by Robson and Power, Just before time was called, the home team had to touchdown several times in quick succession. The following was the team playing:—Pinching (captain); Robson, Gilbert, Wells, H. Duke, Wallis, Mutch, Collins, Simmonds, Brown, (forwards)—Breach and Power; (back)—Gray; (three-quarter-back)—Finch and Maclean (halfbacks).

MATCH THIS DAY.

St. George's Hospital (return) at Battersea Park.

THE servants of this institution dined together under the presidency of Mr. Simpson, of the Dispensary, on Tuesday last, at the White Hart Inn, High Street, Borough, when a very agreeable evening was spent.

STUDENTS' BIBLE CLASS.—The next meeting will be held on Tuesday, January 27. Subject: John xiv. 1-14.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

SKELETON; Cheap. Write offers to A. B. C., "Guy's Gazette" Office, 104, Borough.

VOLUME I, of "Guy's Hospital Gazette," from October 1, 1872, to April 26, 1873; all the numbers are very clean; price 10s.—Address, at the Publisher's, 104, Borough High Street.

Will be published in a few days, 24 pp. Demy 8vo., Toned paper, price 1s 6d, post free 1s 7d.

HINTS ON OPHTHALMIC OUT-PATIENT PRACTICE, By CHARLES HIGGENS, F.R.C.S., Assistant Ophthalmic Surgeon, Guy's Hospital.

"We consider these "Hints" excellently calculated to generalise the practical knowledge of eye diseases formerly only acquired by dressers in the Eye Wards, and though, by Mr. Higgen's original intention, they were "written expressly for Dressers in the Eye Wards," we would recommend them expressly to those who have neglected to hold that appointment, for they consist of a short resumé of what he teaches his dressers during their four months' duty, written in such a plain and concise form, that not only are the diagnosis and treatment of the common diseases of the eye given, but the use of the ophthalmoscope, and the way to find spectacles for hypermetropia, myopia, and presbyopia are also easily to be learnt by any one from these few pages."—GUY'S HOSPITAL GAZETTE.

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The TABLETS of ANATOMY and PHYSIOLOGY are now published as follows:—Ear and Eye, 1s.; Circulat., Respirat., Animal Heat, 1s. 6d. Cranial Ns (Rough Ed.), 6d.; Longmans. Part of the still unpublished tablets may be had from the author. Reviews—"The tablets now so thoroughly recognised as the most useful analyses of classical study."—"Lond. Med. Record." "A mass of condensed information."—"Brit Med. Jour." "Present a co-ordinate analysis of all the important points in as few words as possible."—"Med. Times. & Gaz." "In the plainest language they contain in about one-tenth the space the matter which is found in the most accredited standard works; the author is evidently a sound teacher."—"The Lancet." "They place the essentials before the learner in the clearest and most concise manner."—"Student's Jour. and Hosp. Gaz. "They deserve to rank among the best books of their kind."—"Aberdeen Medical Student."

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Guy's Hospital, S.E.

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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Printed and Published for the Proprietors by ORLANDO GIBBS BRIMMER at 104 Borough High-street, Southwark, Surrey.—Saturday, Jan. 24, 1874.

Guy's Hospital Gazette.

VOL. III.—NO. 18. SATURDAY, JANUARY 31, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

Dr. J. J. Phillips.

Hardly has the grave closed over the remains of Dr. Dickson, when we are called upon to chronicle the death of another of the younger members and of the Staff, Dr. Phillips. There is, indeed, a remarkable similarity between the two sad events that have followed one another so quickly. Like Dr. Dickson, Dr. Phillips was known to his more intimate friends to have had cardiac disease for many years past. He had a loud systolic murmur, which had even been suspected of being due to some congenital defect. However, the affection produced very little disturbance of his general health. He was less able to bear great bodily exertion than some others; he often looked worn and weary, but he did his daily work without complaint, and apparently without suffering. So far as we know, the only time when he had any serious symptoms referable, even indirectly, to his cardiac disease, was in April, 1873. He then had an attack of aphasia. This naturally gave great alarm to those of his friends who knew of it; but to him it seemed rather to present its ludicrous side. He was perfectly conscious, and free from pain, and from all paralytic symptoms, but he could find very few words to express his ideas, and he was not able to write a single intelligible word. In a day or two these symptoms began to subside, and before long they entirely disappeared. So quick was his recovery, that his medical friends had the greatest difficulty in persuading him to go into the country for two or three weeks.

After this attack, he was strongly urged to relinquish one or more of the appointments that pressed so heavily upon him. Besides being Assistant Obstetric Physician to Guy's, he was one of the Assistant-Physicians to the Hospital for Sick Children, and Physician to the Royal Maternity Charity. He was also one of the Honorary Secretaries to the Obstetrical Society. Thus it devolved upon him to edit the successive volumes of the Obstetrical Transactions; and he also prepared, for the Biennial Retrospects of the New Sydenham Society, Reports on the progress of Science in Midwifery and allied subjects. As though this was not enough, he insisted last summer on undertaking the further labour of editing the Guy's Hospital Reports. In addition to his official duties, he had a private practice, which for his time of life was unusually extensive. For more than a fortnight before his death, he had been down every evening to Maidstone, returning the following morning, to visit a lady on whom he had been in frequent attendance for some years past, and whose case had lately become a very anxious one. On the evening of Wednesday, the 20th January, however, he was unable to make this journey. He had during the day suffered from a severe headache, and towards evening he was attacked again by aphasia. These symptoms did not much alarm those about him, who no doubt remembered how quickly similar symptoms had passed off before. He would not allow his servants to send for any one of his medical friends, and he went to bed early. In the morning, when his servant came to call him, he was found to be comatose. His neighbour, Dr. Daldy, was at once sent for; and before long, Dr. Risdon Bennett, Dr. Davies, Dr. Pye-Smith, and Dr. Hilton Fagge were by his bedside. But from the first it was evident that his condition was absolutely beyond hope of recovery. He was deeply comatose, unable to swallow, and breathing stertorously. His pupils were narrowly contracted. His pulse was at first fairly strong, but it gradually became more feeble and quicker His breath grew more and more laboured, and the expired air became cold, while the temperature of the body rose to 103·5. At seven minutes past three he expired, having shown not the slightest indication of consciousness since his alarming state had first been discovered, about seven hours before.

It is much to be regretted that his relatives felt unwilling to accede to the wish expressed by those who had watched his illness, that the exact nature of the attack should be determined by an autopsy. There can, however be little doubt that it was directly or indirectly caused by embolism of one of the cerebral arteries. Possibly it was simply due to plugging of some large vessel; more probably, we think it was the secondary result of the impaired nutrition or softening of some part of the brain, consequent on embolism, and leading to hæmorrhage into the substance of the organ. In any case it must be regarded as a natural consequence of the cardiac disease under which he had so long laboured. And if we think only for him, we can hardly feel that such an end is otherwise than a happy one, for a man so circumstanced. Sooner or later, we know that some catastrophe must have happened, and we cannot but contrast his painless death with the lingering agonies

which our imagination readily brings before our minds as too probably its alternative.

We have already enumerated the appointments held by Dr. Phillips. It must now be added that he had already begun to do good work, in contributing to the literature of the special department to which his studies were devoted. He had published a paper on the "Natural History of Ovarian Disease," and one on "Retroflexion of the Uterus as a Frequent Cause of Abortion," in the Obstetrical Transactions; and he had also written, in conjunction with Dr. Hicks, on "The Mortality after Obstetric Operations," and on the "Treatment of Puerperal Convulsions without Bleeding," in the Guy's Hospital Reports. These are valuable essays, but his professional reputation was far higher than would appear from any mere statement of the work he had done. Probably this was in great part due to the thoroughness and extent of his knowledge. He was no mere specialist, but was remarkably well-informed in all branches of Medical Science. A good illustration of this may be found in the fact that for two sessions he had held the appointment of Demonstrator of Anatomy, and had worked in the dissecting-room most zealously. We do not suppose that there is any other Obstetric Physician in London, or perhaps in Great Britain, of whom this could be said. Then, again, he spoke well in public, and every one who reads the medical journals must remember how constantly he took part in the debates at the Obstetrical Society. But we believe that what, more than anything else, led to the very high estimate that was universally formed of his professional position and prospects was his perfect straightforwardness and integrity of purpose, which were manifest to all who were brought into contact with him. The writer of this notice had numerous opportunities of judging, and he believes that Dr. Phillips' advice to his patients, whether in consultation or otherwise, was invariably dictated simply by a regard for their welfare, and was entirely uninfluenced by any undue consideration of his own pecuniary interest.

But highly as all his professional brethren, who knew Dr. Phillips respected him on account of his medical knowledge and skill, there were other qualities in him which gained him a far deeper regard and esteem from those who enjoyed the privilege of being his intimate friends. His life and conduct had a noble simplicity and purity. The writer knew him well, and does not remember that he ever uttered a single word or expression which he could wish recalled. This is not the place to speak of his religious views or feelings, but he was a regular attendant at more than one place of worship in the City, and to his friends he seemed a most deeply religious man. His gentleness, both of manner and of action, was extreme. There was a charm about his ways, that was recognised by every one with whom he came into contact; and probably he had not an enemy in the world. His kindness and sympathy with others in their griefs and troubles were unbounded. He was always ready to devote his time and care to his friends and their relations in sickness; and at least one of them owes to him a debt of gratitude which, had he lived, could never have been repaid.

He was buried far from London, in a quiet spot among the hills of Wales, close to land which had been the property of his father. It was, therefore, impossible for his colleagues or friends to follow him to the grave. The only tribute of their affection and regard that they could offer was to meet at the Euston Station, before the departure of the train by which the remains were taken away. A little space on one of railway platforms was railed off, and draped with black cloth. The coffin was deposited there for a few minutes, and a Welsh clergyman—the deputy or successor of Dr. Binney, at his well-known chapel—read some passages from scripture, offered a prayer, and addressed a few observations to those who had collected together, and who stood round the bier in silence. The engines were whistling all round, and the roof reverberated the noise of busy life and traffic. But this was far from being an incongruity, and seemed rather to intensify the solemnity of the short service.

The time was too short to admit of invitations being sent to all those who would have wished to be present at this touching ceremony. No notice of it could be published in the medical journals, and the daily papers were just then full of political matters. Yet the attendance was large, it being estimated that at least two hundred persons were present. No complete list can be given of those who attended. We noticed Thomas Turner, Esq., the Treasurer of the Hospital; Sir W. Gull; Drs. Oldham, Habershon, Moxon, Braxton Hicks, Hilton Fagge, Pye-Smith, Stevenson, F. Taylor, Goodhart, Daldy, Aveling, Playfair, Fotherby, Squarey, Wiltshire; Messrs. Bader, J. Stocker, Scott, Davies-Colley, Moon, Eastes and Evershed.

LECTURES ON MEDICINE.

RELAPSING FEVER,

BY DR. WILKS.

(*Continued from page* 131)

Relapsing fever was not recognised in London until the time of the Irish famine thirty years ago, but since this period it has occurred here twice as an epidemic. It is essentially connected with famine and destitution, and has therefore been styled "famine fever." It is not a very fatal disorder, and its peculiarity consists in the total abatement of the symptoms, and their recurrence in a few days.

It is contagious, and like other forms of disease of the same kind is supposed to be due to a specific virus. The accession of the febrile symptoms is sudden, often attended with vomiting and delirium; the temperature may rise to 106 deg. in twenty-four hours, although it usually falls again two degrees. The patient is by this time exceedingly depressed, his eyes are sunken, he speaks with a feeble voice, but the brain is clear. The tongue is furred or slightly brown. There is pain in all the limbs, and this is often complained of bitterly by the patient as his worst symptom; there is occasionally slight jaundice.

These symptoms last on average a week, then quickly subside. The fall of temperature in some cases is so sudden that the patient is momentarily collapsed; thus I have had two cases of the kind, in which the temperature fell in a few hours from fever heat to 2 deg. below normal. After this the patient is comparatively well, and often leaves his bed; but the period is of short duration, for on the fourteenth day he again suddenly has a recurrence of the febrile symptoms, the temperature rapidly rises in twenty-four hours, and the patient is in bed and as feeble and prostrate as ever. The time of relapse appears to be very definite; the period of the first paroxysm and the subsequent inter-

mission vary, but the two periods together almost invariably occupy fourteen days. Thus, if the stage of fever were five days, that of the intermission would be longer; if the stage of fever were eight days, then the intermission would be shorter. When, on the fourteenth day, the febrile symptoms recur, they continue only for about three days and then quickly subside. After this the patient gets well. He may, however, have a second relapse of shorter duration, and even a third relapse.

The remarkable nature of the complaint could never have received a better illustration than it did at this Hospital three years ago. One of our pupils had been appointed at a fever hospital, and being very assiduous in his duties soon caught relapsing fever. He desired to be brought here, when I found him very ill; he soon, however, got better, nd was able to leave his bed. This was on a Saturday, when there happened to be a debate at the Physical Society on Relapsing Fever. Our patient went to the meeting, entered into the discussion, and to the surprise of his audience, said that at that moment he was the subject of the disease, that although he then felt pretty well, he would be found in the Clinical Ward on the following Tuesday with intense febrile symptoms, and all the other indications of the disease. On the day mentioned he was found as predicted, lying in bed, in an extreme state of prostration, and the most violent symptoms upon him.

The disease is rarely fatal, except in places where it is epidemic, and great impoverishment exists. There is no rash, but in some cases there appears a tendency to a purplish mottling on the abdomen.

There was no difficulty in the diagnosis at the fever hospitals, owing to the sudden accession of the symptoms and the absence of the mulberry rash. The first fact excluded typhoid, and the second excluded typhus.

(To be continued.)

PHYSICAL SOCIETY.

The eighth meeting of this society during the present session was held on Saturday last, after the minutes of the proceeding meeting had been read.

Mr. Pye-Smith rose, before proceeding to the paper of the evening, to propose a resolution of condolence on the premature death of the late Dr. Phillips. He stated that many of the students had felt that this would be a suitable mode of paying respect to the memory of Dr. Phillips, who had for several years been secretary to the society; and, after referring to his popularity and interest in student affairs, he proposed a resolution to the following effect:—"That this society desires to express its deep regret at the great loss the pupils of this Hospital have sustained in the sudden death of the late Dr. Phillips, and to convey its sincere condolence with his family on their bereavement

Mr. Ashby expressed great pleasure in seconding the resolution. Probably not many of the members present remembered Dr. Phillips as secretary to the society, but all knew him in the capacity of a member of the staff; and those who had taken advantage of his assistance in the study of obstetrics, as freely given as it was valuable, would join with him in his deep regret, that so noble and useful a member of the profession had passed away.

The members earnestly expressed their desire that the resolution should be passed. The president then called upon Mr. Day to read his paper on "Electricity as a remedial agent."

Mr. Day began his paper by giving a short account of the different forms of Electricity in use, and their modes of application, viz., 1st., Static or frictional; electricity procured by friction; electricity of high tension; current of momentary duration; used in three ways, by passing shocks, by taking sparks, and simply charging called having a bath. This form of bath differs from the galvanic bath in the electricity being of different tension. 2nd..galvanism continuous or battery current; a permanent or direct current from a battery of a variable number of elements; electricity of low tension, used in two ways; first, continuously then called the galvanic continuous current. This is done by keeping both poles steady; 2nd., interruptedly then it is called the galvanic interrupted current; this is the continuous current of Guy's and other people. The interruption is made by the operator; in its application only one pole is kept steady. 3rd.,induced current, Faradization or interrupted current; electricity procured from a battery or cell which causes (or induces) a current in a wire which is parallel to the one in which the current from the battery is passing, and this induced current is the one you apply to the patient. It is then interrupted by a magnetic machine, which is in connection with the machine. Electricity of high tension, current only of momentary duration, used in two ways, 1st., both poles being kept close together picking out each muscle as you want it to contract; or 2nd., by keeping only one pole steady, the other being moved quickly about, (very seldom used). N.B., induced electricity can never furnish galvanism, but galvanism can induced with the aid of an induction coil. He than proceeded to the relation of cases, first mentioning hysterical aphonia, showing that in some cases it did good, and in others no benefit was derived. For the relief of pain, he related an interesting case of neuralgia of first division of the fifth nerve, treated by the galvanic continuous current. Passing to cases of paralysis, Hemiplegia due to hæmorrhage or embolism; seven cases, three being relieved. Induced current, form of electricity to be used, stating that it never should be used early. The treatment of rigidity in paralysis, he recommended the galvanic continuous current to the overacting muscles or the induced current to the weakened muscles. Paralysis agitans—7 cases, no relief. Chorea—134 cases, 74 cured, 9 relieved, and failed in 13,—all treated by static electricity. Hysterical anæsthesia to be treated with the induced current; if the muscles become wasted the galvanic interrupted current to be used—10 cases, 8 cured, 1 relieved, 1 no relief. Essential paralysis of children—7 cases treated by static electricity, sparks being drawn from the spine and limb, 3 cured, 2 much improved, 2 no relief; 42 cases treated by galvanism or induced current, 2 cured, 28 much improved, 3 unrelieved; begin treatment as soon as possible, using the galvanic interrupted current till the muscles respond to the induced current, then go on with that or *static electricity* if possible. Facial paralysis—16 cases all cured. Lead palsy—galvanic interrupted current, 9 cases, 5 cured, 4 left fit for work. Static electricity—18 cases, 16 cured, 2 relieved. He could not recommend it in cases of ptosis but thought that the galvanic continuous current might be of use in cases of atrophy of the optic nerve and intolerance of light. Locomotor ataxia, 18 cases, 15 with galvanism, 1 induced current, both currents 2, 1 cured, 9 relieved, 6 unrelieved. The galvanic interrupted current to spine is the form of electricity to be used. Progressive muscular atrophy, 5 cases, treated with galvanic interrupted

current, all very much relieved. Wry neck, 6 cases, in none any relief, but he hoped that they might be treated in the following way, galvanic continuous current to the overacting muscles, and induced current to the weakened ones. Scriveners palsy, 2 cases, 1 cured 1 very much relieved, treated in the way just recommended for wryneck. Paralysis caused by pressure—12 cases, most of them cured, static electricity or induced current. Paralysis after dislocation—8 cases, all cured, static electricity or induced current. Paraplegia —8 cases, 2 only relieved. Chronic rheumatism—10 cases, (static electricity,) 6 cured, 2 unproved, 2 no relief. Induced current—30 cases, 1 cured, 9 relieved, 6 no relief. Amenorrhœa—46 cases, shocks being passed through pelvis, 33 cured, 9 no relief.

Mr. Harsant regretted that the reader of the last paper, since he was not present, had not taken the trouble to get a substitute to open the debate. He thought the society ought to be congratulated on the very practical paper which Mr. Day had submitted to them, which did credit even to an M.R.C.S. The cases in which he had generally seen galvanism used were not much benefitted by it—they were hemiplegia and paraplegia, but he had seen much good derived from it in one or two cases of lead paralysis. Mr. Day had not mentioned a class of cases which he had known to be considerably improved by it—namely, habitual constipation.

Mr. Ashby said there was one fact of interest in connection with this subject, which Mr. Day had not referred to in his interesting paper, and that was that fifteen years ago there was only one metropolitan hospital where electricity was systematically used as a curative agent, and that hospital was Guy's. He was not quite sure, however, that the present state of electro-therapeutics at Guy's was quite so much a matter of congratulation. One of the first difficulties that presented itself to beginners was the selection of proper apparatus for use. There has been such a variety of apparatus in use, and such various modes of applying them, that it is very difficult to compare results and ascertain the real value of any line of treatment. One often hears, for instance, of a certain number of cells being used, when their effect must greatly vary according to the kind used or their size. Then, again, there is great difficulty in obtaining batteries which combine portability, fair electro-motive force and moderate expense. The physicist, working in his laboratory, can employ any number of Grove's or Bunsen's cells, but these batteries would be utterly out of place from their noxious fumes and complicated arrangement in a ward or dressing-room. And yet one requires a battery of considerable power. For, suppose the constant direct current to be applied to the spine, and assuming the current or a portion of it to travel down the cord considerable resistance is offered to its passage. Nerve tissue offers twice the resistance of muscle, and muscle considerably more than water. The poles of the battery are separated about 18in. apart, and unless the current be of moderate intensity the effect must be very small. In batteries on the Cruikshank principle, consisting of series of zinc and copper plates, packed with sawdust, moistened with sulphuric acid, though portable and tolerably constant, are of but low intensity from their high external resistance. On the whole the bottle bichromate batteries, though not so constant as the above, seem to be better suited to clinical work. With regard to intensity coils there is not much to choose. A small induction coil, worked by a single bichromate cell, is far superior and more manageable than the everlasting rotating magneto-galvanic machine. The interrupted current, supplied by an intensity coil, seems to act only as an irritant, and not from possessing any specific influence over the tissues. It is often useful in hysteria from arousing the whole energies of the patient to overcome her morbid and perverted sensations. In acute muscular atrophy and other wasting diseases it is a convenient way of applying a frequent stimulus to the tissues whose nutrition is suffering from disuse. Statical electricity is a fast decaying agent for therapeutical purposes. Its clumsy and painful shocks are more likely to frighten than to relieve the patient, and is so much less under the operator's control than the other forms of electricity. On the other hand, the continuous current is finding fresh fields of usefulness every day. Pflüger has recently demonstrated on the muscles of frogs that the current has different effects according to which pole is used. Thus, if the positive electrode be placed at a point nearer the origin of the nerve than the muscle, the current descends along the nerve to the negative placed nearer its termination, there will be an increased excitability in the neighbourhood of the positive. The different effects may thus be utilised in spasmodic and paralytic diseases. Thus, scientifically applied, there may be some chance of rescuing this department of therapeutics from impudent quacks and equally objectionable empiricism. He considered that we had made a few steps lately towards the more scientific employment of drugs; and believed there was as great a future as there was wide a field for the application of electricity to therapeutics.

Mr. Pye-Smith could not speak of electricity scientifically as Mr. Ashby had done, but he had had some practical experience with it. He did not think it could be said to *cure* chorea with any certainty, since chorea naturally tended towards recovery. In reference to the eye cases, he thought it right to mention that Mr. Kiddle had continued the experiments, and without success. Whilst in the Charity he had tried it in amenorrhœa but without result. He had known retention of urine from paralysis of the bladder after labour to be cured by galvanism. Mr. Day was at a loss to explain the uselessness of galvanism where perfect contractility of the muscles was retained, he believed the reason for this was, that it was usually in cases where the mischief was central that perfect contractility remained. He mentioned a case in which he had been able to obtain contraction of the uterus by galvanism, where ergot had failed. And remarked upon its use in suspension of respiration from chloroform, or after immersion.

Mr. Lamb was very pleased with Mr. Day's practical way of treating his subject; he thought that it would be more beneficial to our future patients to discuss treatment rather than diagnosis and pathology, as was often done. He remarked upon the necessity of patience and regularity in the use of galvanism before we could fairly judge of its efficacy in acase. As to lead paralysis he had seen it of much use in some cases under Dr. Moxon, which he narrated. He had also found it of great advantage in the atrophy of muscles which sometimes takesplace in a limb which has been kept in splints a long time for fracture. He could testify to its actual benefit in some cases of hysteria, though in many it was undoubtedly of advantage only as a scientific way of giving a good slap.

Mr. McKern explained that the advantage of the induced current in lead paralysis was owing to its slight chemical action. Induced electricity had a deleterious action on the retina, and therefore should not be used in affections about the eye. He thought both the moral and physical properties of electricity were of advantage in hysteria.

Mr. Waterhouse had seen a case in which galvanism coupled with artificial respiration had been successful

in restoring a man who had ceased to breath under chloroform. He had observed marked improvement in some cases of lead paralysis treated by it. He would ask Mr. Day if he could tell him the value of pulvermacher's chains.

Mr. Tyson wished Mr. Day had spoken more of the diagnostic value of electricity, and mentioned some cases in which it was of use in this manner, especially in one case diagnosed as sprained ankle, which Mr. Duran and himself had shown to be due to paralysis of some of the muscles of the leg by this means.

Mr. Metcalf remarked that Dr. Wilks said that a good way to cure hysteria was to rouse the patient's indignation. This was the way the black draught acted—by making them get out of bed so often. He thought that galvanism acted in this way. He was sorry to see the old static electricity going out of fashion, since he believed it was the best form in many cases.

Mr. Davey was sorry that Mr. Ashby had such a poor opinion of the magnetic machine, he had seen very good results with it, and mentioned some cases which had been cured under its influence. He could not agree with Mr. McKern that the continuous current had but little chemical action, it was the magnetic machine which was devoid of this property.

Mr. Eastes remarked that electricity had one or two principal properties, one of which Mr. Ashby had already mentioned, namely to keep muscles in repair in cases of central injury, which might improve in time, such as slight apoplexy where the muscles might irreparibly atrophy, if they were not kept in occasional action by some such means as galvanism. In cases of facial paralysis from cold it was advisable not to use galvanism oftener than once a week, or the paralysed muscles might become over stimulated, and cause the originally paralysed side of the face to be drawn.

Mr. Lamb gave some experiences favourable to the galvanic chain belt.

Mr. Bevan thought we ought not to speak generally of the advantage of electricity in any special disease, for many diseases might be divided into functional and organic. The functional naturally tended towards recovery. For instance take chorea. Functional cases as from fright would recover, but with valvular disease galvanism could do no good. The same with facial paralysis, or amenorrhœa. He thought galvanism most useful in the functional cases of infantile paralysis.

Mr. Rendall thought highly of the sedative advantages of electricity, and gave cases showing its value.

Mr. Paul narrated a case bearing upon Mr. Eastes' observation, that a previously paralysed part might become over-stimulated by the use of galvanism. The case was one of retention of urine which had been treated in this way by Mr. Durham.

The hour being late, the President called upon Mr. Day to answer the remarks which had been made upon his paper. A vote of thanks was then proposed by Mr Pye-Smith, and seconded by Mr. Hetley to Mr. Day, for his valuable paper on "Electricity as a remedial agent."

The meeting then adjourned.

MEDICAL WARDS.

—o—

The following cases were admitted from Jan. 22 to Jan. 28, 1874.

MIRIAM (Clinical).

28—Peritonitis

JOHN (Clinical).

13—Diabetes Mellitus
14—Morbus Cordis—Mitral

PHILIP

9—Bright's Disease
10—Pleurisy
11—Alcoholism
12—Rheumatism
25—Gastric Ulcer

STEPHEN

3—Phthisis
4—Bronchitis
8—Bronchitis
37—Partial Paralysis
38—Dysentery

MARY.

24—Eczema of Face

ADDISON.

5—Phthisis
11—Facial Erysipelas
15—Dyspepsia
35—Lupus of Face

ASTLEY COOPER

4—Phthisis

SURGICAL WARDS.

—o—

The following cases were admitted from Jan. 22 to Jan. 28, 1874.

ACCIDENT.

1—Fractured Thigh
6—Injury to Neck
8—Fracture of Tibia
13—Immersion—Bronchitis—Fracture of Os Calcis ?
15—Fracture of Larynx or Trachea ?—Emphysema
17—Fracture of Tibia and Fibula
18—Acute Synovitis
19—Contusion of Abdomen—Peritonitis
24—Fracture of Fibula
25—Fracture of Tibia and Fibula
31—Fracture of Tibia snd Fibula
32—Scalp Wound—Concussion

CORNELIUS.

11—Sprain of Back
14—Contusions
16—Synovitis

LYDIA

1—Lupus of Nose
7—Ulcer of Leg
13—Tumour of Thigh—Removal—Death

JOB.

3—Disease of Hip
15—Injury to Fingers—Amputation
23—Femoral Aneurism

MARTHA

2—Disease of Tarsus
4—Webbed Fingers
10½-Disease of Ankle-joint
14—Old Fracture of Tibia and Fibula
15—Scalp Wound—Injury to Ear

LAZARUS.

3—Sinuses about Knee-joint
4—Injury to Abdomen
10—Specific Ulceration of Leg
20—Periostitis of Humerus

NAAMAN.

No Admission.

LUKE

5—Disease of Hip-joint
11—Fistula
17—Epithelioma of Lip
18—Cancer of Axilla, recurrent—Death
18—Fracture of Jaw—Necrosis
21—Disease of Hip

DORCAS.

13—Sebaceous Tumour at back of Neck
19—Ulcer of Leg

CHARITY.

2—Loose Cartilage ?
6—Thecal Abscess—Necrosis of Phalanx
26—Disease of Knee

BARNABAS (Ophthalmic).

1—Staphyloma
2—Central Corneal Opacity
12—Corneo Iritis
13—Cataract
14—Cataract
15—Cataract
19—Cataract

RUTH (Ophthalmic).

31—Tinea
36—Staphyloma
44—Corneo Iritis
45—Cataract

OUR NOTE BOOK.

—o—

DIAGNOSIS BETWEEN LUPUS AND RODENT ULCER.

1. Lupus may ba found in comparatively early life.
   Rodent ulcer appears late on in life.
2. Lupus appears in unhealthy subjects, often in those of a "strumous" diathesis.
   Rodent ulcer attacks otherwise healthy subjects.
3. Lupus appears first as a papule.
   Rodent ulcer appears as a very hard tubercle.
4. Lupus is nearly always found upon or near the nose, from which it may spread downwards to the angles of the mouth.
   Rodent ulcer attacks widely the checks, lips, &c.
5. Lupns does not go deep ; as a rule it confines itself to the skin and mucous membrane
   Rodent ulcer may go very deep, infiltrating even the periosteum of bone, and the deeper fasciæ, *e.g.* the Temporal Fascia.
6. In Lupus yellow crusts form.
   Not so in Rodent ulcer, where there is an unhealthy sanious discharge.
7. Lupus heals at last, or heals at least in one spot while it breaks out in another. It is very rare for Lupus to do even this.

QUESTION OF TAPPING IN PLEURITIC EFFUSION.

In such cases early tapping has lately been recommended ; because—

(a) The more the effusion is allowed to increase, the greater is the disadvantage at which the capillaries and absorbants are placed as regards performing their task of absorption.

(b) The longer the effusion lasts the thicker grows the coating of lymph on the inner surface of the pleura which also will tend to greatly hinder the process of absorption.

DIAGNOSIS OF INGUINAL HERNIA.

In distinguishing this from the Femoral variety it is not sufficient to take Poupart's ligament as the guide, for a Femoral Hernia, instead of descending down the thigh, frequently when of considerable size turns up towards the abdomen ; and, on the other hand, an Inguinal Hernia, after emerging from the abdomen, if it do not remain stationary, passes down into the scrotum or labium. The spine of the pubes is the safest guide when the finger is placed upon it. If the Hernia be a Femoral one it will be outside the finger, for it descends beneath Poupart's ligament outside Gimbernat's ligament ; on the other hand, if the Hernia be Inguinal and not merely a bubonocele, it will be to the inner side.

OPENING THE SAC OF A HERNIA.

Each case must be settled on its own merits ; thus—The sac should if possible, not be opened, if the Hernia is a recent one, if in all probability the bowel is sound. It will be advisable again to open the sac if the Hernia have lasted four or five days, if the textures over it are red and œdematous, if the bowel itself is seen through the sac to be in a sloughing state.

FOOTBALL CLUB

—o—

GUY'S I. v. ST. GEORGE'S

The return match with St. Georges, which was played on their ground at Battersea Park, last Saturday, we won by two goals and five touchdowns to nothing. For the first few minutes the game was carried on unpleasantly near our quarters, but the Guy's men soon warmed to their work, and took the ball down into neutral ground, where after some sharp play on both sides, Robson getting hold of the ball made his mark, and Gray undertaking the place, by a capital kick, sent the ball flying over the goal. Shortly after this goals were changed, when we penned our adversaries, Robson nearly kicked another goal, the ball passing over the post; but nothing of real importance occurred, until Gray, who played in fine form throughout the match, ran in and touched the ball down close to the

touch-line, the place which was a very difficult one, was by a splendid kick converted into a goal by the same player. When time was called, the ball was still well in the St. Georges' quarters, they having had to touchdown two or three times in self defence. The following was our team :—Pinching, (captain); Robson, Gilbert, Rendall, Wells, Welchman, Hetley, Mutch, Brown, Collins, (forwards); Breach and Wallis, (backs); Gibb, (three-quarter back); Gray and Maclean, (half backs).

MATCHES THIS DAY.

Guy's I. *v.* St. Mary's Hospital, at Blackheath; Guy's II. *v.* St. Thomas' Hospital, (II.) at Clapham Common.

APPOINTMENTS.

On duty for the month ending February 28th.

HOUSE PHYSICIANS—

Mr. R. J. Pye-Smith and Mr. T. Eastes.

JUNIOR HOUSE-PHYSICIAN—

Mr. J. Lacy Morley.

HOUSE SURGEON—

Mr. W. H. A. Jacobson.

JUNOR HOUSE SURGEON—

Mr. H. Hetley.

RESIDENT OBSTETRIC ASSISTANT—

Mr. F. T. Paul.

JUNIOR RESIDENT OBSTETRIC ASSISTANT—

Mr. H. Williams.

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All communications to be addressed to

The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed:

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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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Guy's Hospital Gazette.

VOL. III.—NO. 19. SATURDAY, FEBRUARY 7, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

LECTURES ON MEDICINE.

—o—

SCARLATINA.

BY DR. WILKS.

(*Continued from page* 139.)

This is the worst form of specific disease existing in our country. It is always more or less amongst us, and often puts on the most virulent character. The mortality has sometimes amounted to 30,000 annually, but its evils do not end here, for, owing to its various complications, it may be followed by kidney disease, arthritic affections, deafness, and perhaps abscess in the brain. Although it is the most fatal and formidable of diseases yet it may assume the mildest form, and patients may go through its stages without being aware of the nature of the slight ailment which affects them. In schools and public establishments every variety of the disorder may be observed between the most virulent form on the one hand, and a disorder characterised only by a slight sore throat on the other. This has given rise in the public mind to an opinion that there is a mild variety—"scarlatina"—to be distinguished from the more severe "scarlet fever." I would ask you never to assent to these popular errors as medical men sometimes do, it being your duty to instruct your patients and not to assist in perpetuating their delusions.

In its simple form it runs a more rapid course than any other of the specific diseases. The incubation is from three to six days, but several cases have been recorded where it is less, as for example, where a child has come from school with the disease upon him, and in twenty-four hours afterwards some of his brothers and sisters have sickened with the complaint. The febrile symptoms sometimes are of a most violent kind, whilst in the milder form of the disease they are scarcely noticeable. In the former case they may be ushered in by delirium and convulsions, intensely hot skin, thickly-coated tongue, very quick pulse, and at the end of twenty-four hours—as it is seldom before this that the thermometer is used—the temperature may stand at 104 deg. or 105 deg. At the expiration of this time the rash has appeared, in fact the whole of the surfaces of the body, both without and within, are in an intensely hyperæmic condition. And, first, I would warn you not to seek for the first appearance of the rash upon the face, for if you do, and the child be wrapped up in bed, you may entirely overlook its existence. You will generally first notice it about the neck, and then on the trunk, and soon you will see the whole body, including the limbs, and perhaps the face, covered. You will now find the body as red as a lobster, or as if the patient had been put in a hot bath and violently rubbed. Observed at some distance, the skin looks uniformly red, but on closer examination it will be observed that the colour does not seem as if it had been painted smoothly over, but as if scattered in minute points over the surface. The eruption, indeed, is made up of innumerable very minute points. Sometimes the whole surface is not affected, but the rash is seen in parts only, as on the chest or abdomen, and, at the same time, on portions of the legs. In less severe cases, some patches of red rash are seen, and often on the flexures of the knees and about the ankles. In simple cases of scarlet fever, the rash is a mere exanthem, and therefore fades on pressure, but there often accompanies it a papular rash, causing the skin to be quite rough when the hand is passed over it, and sometimes creating a suspicion of the onset of small-pox. Not infrequently, also, some of these papules undergo a further stage of in-

flammation and distinct vesicles are formed. Last year I saw two cases where so large a crop of vesicles came out on the forearms that it suggested to the medical men a complication of small-pox. The scarlatina rash lasts four or five days and then fades, beginning to disappear at those spots where it first began. Then desquamation commences by an universal shedding of the epithelium, and sometimes as regards the hands by the throwing-off of the cuticle like a glove. The desquamation, I must tell you, is not peculiar to scarlatina, but in this disease it occurs in an excessive degree. There is never an extreme congestion of the capillaries of skin without a necessary death of the epithelium and a consequent shedding of it. In all erythemas naturally or artificially produced this may be observed.

Now, I told you there was every reason to believe that the internal mucous surface was affected in a similar way to the external, and thus when the rash commences to appear it may be observed that the mucous membrane of the mouth is intensely red from capillary injection. The tip of the tongue is covered with minute red points, and the papillæ may be seen projecting through the white fur. The soft palate and tonsils are red, swollen, and covered with a tenacious secretion. The glands beneath the jaw are swollen, forming a large disfiguring mass in the neck. The congested or inflamed condition of throat often extends to the back of nares and even along the passages of the nostrils, by which they become blocked with secretion, and which is often of an offensive nature. The inflammation also involves the Eustachian tubes causing great pain in swallowing. If the patient has been sick, some casts of gastric follicles have been found showing how the whole alimentary tract is involved. The child, in a moderately severe case of scarlet fever, remains in a most deplorable condition for four or five days—the high temperature is kept up, skin dry, great swelling of neck, difficulty of swallowing or of breathing, on account of swollen and inflamed state of throat and nares, and from these perhaps there is a discharge. Desquamation then takes place, and recovery ensues. If the urine is carefully examined there may sometimes be found in it some tubular epithelium.

This case I have spoken of may be called (1) *Scarlatina simplex*. The form I have alluded to where the patient is unconscious of having had the disorder is called (2) *Scarlatina sine eruptione*. It sometimes happens, and these cases are of the most fatal kind, that the rash is slight, but the whole virulence of the disease is concentrated on the throat; the neck externally becomes enormously swollen, suppuration may occur, and sometimes sloughing, whereby the whole of the skin of the neck is destroyed, and death then sometimes ensues from implication of the larger blood-vessels. This is the (3) *Scarlatina anginosa or faucium*.

And now I must draw your attention to the affections of the kidney, which is so often a complication of scarlatina. You know that dropsy very frequently follows scarlatina, and that the urine becomes brown, of high specific gravity, and contains inflammatory casts, epithelium, and blood globules. It had long been observed that this dropsy came on from ten to fourteen days after the onset of the fever, and that the latter had been so slight that the patient had scarcely kept his bed; therefore, the opinion naturally arose that the nephritis was due to cold acting on a person who had not paid sufficient heed to his disorder. Such an opinion is now held by many, yet against this view must be placed the fact of the excessive proneness of scarlet fever subjects to dropsy; as it is sometimes seen accompanying the worst forms, and even occurring at the onset of the disease, whilst the patient is kept warm in bed. It is therefore thought, and this is my own opinion, that the kidneys are prone to epithelial changes, ending in inflammation, in all varieties of scarlatina; that in the scarlatina simplex, little more occurs than a slight desquamation of epithelium, whilst the force of the disease is expended on the skin; that in the scarlatina anginosa the whole virulence of the poison is concentrated on the throat, but that there is another form in which all the outward manifestations of the disease are slight, but the whole violence of the disease is thrown upon the kidney. In this case of course the patient would have been thought to have had the disease mildly, but the epithelial change is meanwhile going on in the kidney, when at last the tubules become choked, the circulation arrested, and the character of the urine is changed, and dropsy appears. The latter, therefore, would not be evident as a rule until some days had elapsed. If the patient had been out and exposed to cold this might be an additional exciting cause for the development of the nephritis, but I cannot look upon cold as the originator of it. You may remember that nephritis occasionally is associated with other febrile disorders. If this be true the renal disease should not be regarded so much a complication as a variety of the disease, and be styled (4) *Scarlatina renum*.

There is yet another variety of the disease (5) *Scarlatina maligna*, that form in which the poison is so intense that it kills its victim before the usual phenomena of the disease appear. He is no sooner taken ill than he becomes rapidly collapsed, pulse scarcely to be felt, the whole surface of the body livid, general torpor, and death in a few hours. Perhaps petechial spots may appear on the legs, or some hæmorrhage from the mucous membranes. If there is no history of contagion, the rapidity of the illness will scarcely leave a doubt as to its nature. For example, I lately saw a boy who was playing with his school-fellows on Saturday afternoon, complained of being ill on Sunday, although he was up. On Monday morning the medical man was sent for, and found him collapsed; in the afternoon I saw him, he was then dying, almost insensible, skin livid, hands and feet purple, and pulse of 160. I said the only disease it could possibly be was scarlatina, and this opinion was confirmed by other members of the family subsequently having this disease.

As regards other symptoms and complications, there is the renal nephritis already alluded to, but a commoner complication than this is a secondary fever into which the patient falls. You may observe a large number of your cases suffer in this way. There is only one or two days of convalescense when the child again becomes feverish, the temperature being three or four degrees above normal, the skin very dry, tongue furred, and pain in all the limbs. Very often the joints swell, and the patient is said to have a rheumatic attack. It is thought by some to partake rather of the nature of pyæmia, and then its source has been looked for in the sloughing glands of the neck, but since this is not always present the explanation is not satisfactory. It is remarkable that further complications are then liable to ensue, as pericarditis, and endocarditis. Thus it is not unusual to hear a patient trace his heart disorder to a scarlatina suffered many years before. The arthritic affections may be only another phase of the scarlatinal disorder, and it is remarkable that the dengue of tropical climates is a complaint in which arthritic pains and a red rash are combined. With this secondary fever there is often a constant discharge from the nose and the ears, the latter sometimes leading to permanent deafness. Sometimes when the rash has appeared this secondary fever continues, and

thus the temperature remains permanently high for three or four weeks.

Scarlatina is eminently contagious, the poison being given off from the surface of the body and from the lungs. The blood is also said to contain the virus, and of late it has been pretty satisfactorily shown that the epithelial scales contain the poison, and that if these are swallowed they will set up the disease. The case of a desquamating boy milking cows, and those who partook of his pail catching the disease may be mentioned in corroboration. The poison attaches itself to articles of furniture for many months, and may be conveyed by clothes, and probably by letter.

The treatment is, in the first place, to procure as much good air as possible to surround the patient, and to give him cooling drinks. Stimulants according to circumstances.

(To be continued.)

ADVICE GRATIS.

Passing the time at Guy's, you might perhaps for all evidence to the contrary, be induced to think that advice always comes from a warm sympathy with the person who is directed by it. A great deal of advice is given gratis at Guy's, graduated in circumstance from the fine old quality to be got from the seniors in the wards, to the somewhat green though generous produce of the "Surgery"—good and sound, only wants keeping. But the point before us is, that this graduation does not affect the quality of sympathy which like the Guy's brand on our several vintages is equally fixed on all.

Considered without reference to the Hospital though, one soon sees that all advice is not of sympathetic origin. In fact advice may be divided into three kinds from this point of view. For you will not long observantly watch advisers at their work, without noticing that some sympathise with the object of their advice, others don't care a bit about him, while yet others don't conceal their dislike of him. In short advisers are thus either *sympathetic*, *apathetic* or *antipathetic*.

This difference is apt to escape notice, for the manner does not always reveal it; well-bred persons will give any of the three sorts of advice with the bland tone of self-respect their breeding has elicited in them. The three sorts of advice, the sympathetic, the apathetic, and the antipathetic, must be discriminated by the *matter* they convey, I won't attempt to classify the matter of the stuff given so profusely as advice; its variety and amount are so immense, that even if the quality were encouraging, the science of funguses would be nothing to it. Why, whatever motives a man admires, and finds himself too crank to work under, he tries on somebody else as if to go pure at least by proxy.

When one won't or cannot classify, one must serve oneself with *types* of the kinds that are signified. I will adopt this easier plan now, and show a type of each kind. Thus the sympathetic adviser desires to see the advice succeed; he joins in the aim and is at one with the future courseof the affair; the type of his advice is "let me help you." The apathetic adviser does not care one way or the other; the party may please himself, and the substance of his advice becomes a variety of "do as you like."

While the antipathetic adviser will see the object much improved, he suggests the doing away of one and another of the characters of the fellow, until he were all abolished or transformed; in short the whole sum of his advice might be typified in the suggestion, "Get thee and hang thyself." Now, which of these forms of advice is the most creditable to the kindness of the adviser is clear enough; but which is really the best for the recipient is another kind of question, and requires other worthy considerations. Perhaps it does not make much difference to the advised whether the adviser wishes to help him, if he can get knowledge or means out of him to help himself, nor whether the adviser says to him "do as you like" when he is pretty sure to do the right thing; while he is generally not at all likely to hang himself if only to show his independence. This you will see is in point so far as the applicant for advice wants what is in the power of the adviser to give, or in his own power to get from him. When, for instance, he goes to the other for information, consulting him as he would a map; or for assistance, getting a lift from him just as he would from a vehicle going in a convenient direction.

But this is not the only sort of advice, indeed advice got so is scarcely adviee at all. The property which characterises *advice* as distinguished from *information* and *assistance*—at least from the point of the person advised—is this, That the adviser takes his place in circumstances that are too much for him. The question is, "What would you do if you were me?" (He ought to say "if you were I," but probably wouldn't the English are so far at issue with their grammar). The adviser may on his part, as we have seen, be either sympathetic, apathetic, or antipathetic, but the sincere seeker of advice does not recognise this. The latter two kinds are by no means what he would accept. He desire to be friendly-guided, and goes to give himself up for this purpose It is this self-surrender that makes sacred the claim of the seeker of advice, especially of advice gratis. Not only is there the necessity that moves your pity, but the trust that relies on your condescending to interest yourself in his welfare. When seekers of advice try to *buy* it by bringing a present as they anciently did to the oracles, or as they now offer from a shilling to a guinea as the doctor's fee, the notion is a bad one. Sympathy comes down to a shilling's worth. At Guy's where advice is given gratis the sympathy is untainted by odious comparison with coin; if it were otherwise, the peculiarities of the adviser would assert themselves, and we should see in our Surgery varieties of quality in the advice. Under such circumstances you would get from each dresser a shilling's worth of himself. Thus, suppose the advice to be about an Irishman's molar tooth. The sympathetic dresser would think what further service the tooth might be, and say, "Let's see if stopping will do any good." The apathetic dresser would say, "Now, then, if you're going to have it out sit down." Whilst the antipathetic dresser, after putting Paddy in a chair, would wrench his Fenian head to and fro, drowning the enemy's yells with "Don't make that noise, it doesn't hurt you." But of course as it is, this is never so, the sympathy is universal, it never comes down to the level of lucre. Every tooth is estimated with the most sympathetic consideration, for sympathy is kept high and pure by the pity the poor applicants command.

On the other hand, when money is to follow, the adviser is placed awkwardly to furnish the money's worth; so that he must have the air of a well-intentioned divinity, however crossed by modesty and helplessness. His sympathy, no longer pure, he is obliged to do something for his money, and perhaps becomes injuriously active; advice gratis is better.

No doubt a paternal government should select the truly benevolent doctors, Guy's men for instance, and after supplying their modest wants, supply them gratis to the sick of all classes, The public being particularly requested not to offer fees to the doctors.

PILOCEREUS SENILIS.

MEDICAL WARDS.

—o—

The following cases were admitted from Jan. 29 to Feb. 4, 1874.

JOHN (Clinical),

3—Erythema multiforme (?)

MIRIAM (Clinical).

18—Hæmaturia
21—Acute Rheumatism

PHILIP

9—Ataxia
12—Emphysema
14—Epilepsy
40—Disease of Heart and Kidneys

STEPHEN

11—Gout
12—Scurvy
14—Fits
16—Rheumatism
23—Abdominal Tumour—Abscess (?)
38—Hæmaturia
41—Mitral Stenosis

MARY.

2—Fits
20—Bronchitis

ADDISON.

28—Puerperal Pyæmia
33—Phthisis—Albuminuria
37—Mitral Disease
39—Chlorosis

ASTLEY COOPER

6—Heart Disease nnd Pleurisy

SURGICAL WARDS.

—o—

We are indebted to Mr. J. Farrant Fry for the following case of

RUPTURED POPLITEAL ANEURISM—AMPUTATION—
—TRANSFUSION.

H. G. æt. 74, admitted January 17th, 1874. Patient has always been a healthy and temperate man. His occupation was that of an engineer until four years ago, since when he has been engaged as an interpreter. Father died of heart disease. Between four and five years ago he, by chance, felt a small hard swelling the size of the top of his thumb in the left popliteal region, which was not painful and did not pulsate. He thought nothing more of the swelling until about a month since, when (after a long walk) it pained him, and the tumour throbbed "very heavily," being about the size of an orange but rather oblong. From this time the pain occurred at intervals after any exertion, but the swelling has been gradually increasing in size, especially during the last week. This morning patient walked into the City from Peckham, but was obliged to be taken home about 2 p.m., as he felt very faint and suffered great pain in the left leg which began to swell. He was seen by a surgeon who sent him to the Hospital, where he was admitted at 10.30 p.m.

On admission—Patient has an utterly bloodless appearance and is scarcely conscious, skin cold and clammy. Pulse 80, feeble and readily compressible. The left leg from the middle of the thigh to rather below the knee is very distended and hard. No pulsation felt in popliteal space. Femoral artery pulsates but anterior and posterior tibials cannot be felt. Mr. Colley immediately amputated through the thigh, several clots being removed from the flaps. Brandy 1 oz. every four hours, sumend. Just after the operation and whilst taking some brandy, patient appeared to be choked, stopped breathing and was pulseless. This lasted but a few seconds, and in a short time patient was asleep, breathing easily. Pulse 86.

Jan. 18—2 a.m., patient became pulseless, ghastly and ceased breathing. The house surgeon (Mr. Jacobson) opened the right median basilic vein and injected about 10 oz. of a solution of phosphate and chloride of soda. In a few seconds patient opened his eyes and became conscious. Pulse 88 and fairly strong.

4 a.m.—Patient again appeared choked whilst swallowing some brandy. Slight oozing from stump which was more firmly strapped. Pulse 64.

6 a.m.—Very restless; attempting to get out of bed, some bleeding, which ceased on raising the stump and placing a sand-bag across the thigh. Pulse 64.

7 p.m.—Has slept most of the day, but when awake is very restless. Morph. acet. $\frac{1}{4}$ gr. in brandy. Pulse 98, very feeble.

8 p.m.—Is with difficulty kept in bed. Pulse 106. Morph acet, $\frac{1}{4}$ gr. sub. cute.

11 p.m.—Patient seems exhausted, and now is quiet and apparently conscious. Pulse 118 very small and weak. Mr. Jacobson opened the left median basilic vein and by means of a funnel, gum-elastic tube, and canula poured about 30 ozs. of saline solution into his veins:—Soda Chlor. 1 oz., Phosph. 3 grs., Carbonat. 20 gr., Ex. Aq. 1 oz. The pulse, which just before giving the injection was 124 and very compressible, improved rapidly, falling to 96 and strong. Patient also at first seemed roused but the good effect soon passed off, breathing became oppressed, pulse 104, and it was at first thought a clot had been carried into the pulmonary artery. After a little time these more serious symptoms passed off, and patient fell asleep, breathing quietly.

Jan. 19, 3 a.m.—Pulse almost imperceptible, 118. Breath quick and labored. Patient continued much the same until about 9 a.m., when he died quickly.

The P.M. will be given in a future number.

—

The following cases were admitted from Jan. 29 to Feb. 4, 1874.

ACCIDENT.

5—Fractured Tibia and Fibula
6—Fractured Tibia and Fibula
12—Old Compound Fracture of both Bones of Leg

JOB.

4—Contraction of Toe—Amputation
24—Diseased Hip

CORNELIUS.

1—Sprained Ankle
4—Fracture of Tibia
5—Fracture of Fibula
11—Fracture of Fibula
16—Acute Synovitis
17—Fracture ot Fibula
18—Sprained Ankles
19—Incised Wound over Left Buttock

LYDIA

3—Sore to inner side of Knee
10—Hare-lip
13—Abscess in Popliteai Space
14—Diseased Hip

MARTHA

12—Chronic Synovitis

NAAMAN.

7—Ulcer on Leg
16—Old Sore after Injury

LAZARUS.

2—Hæmorrhoids
4—Perinæal Abscess
18—Rupture of Muscular or Ligamentous Fibres about right Hip
21—Ulcer on Leg

LUKE

9—Fistula in Ano
10—Stricture of Rectum
11—Fistula in Ano
13—Tuberculous Testis
14—Cystitis
18—Abscess in Submaxillary Region
19—Extravasation of Blood into Perinæum
20—Epithelioma of Lip

DORCAS.

9—Abdominal Aneurism

CHARITY.

2—Hysterical Knee
6—Sequelæ of Erysipelas
7—Bruise of Right Leg
10—Sub.-mammary Abscess
11—Suppurating Bursa Patellæ
12—Bruise of Perinæum and lower part of Abdomen
14—Carbuncle

STUDENTS' BIBLE CLASS.—The next meeting will be held on Tuesday, the 10th inst., at 6.30 p.m., at Hibernia Chambers, London Bridge. Subject—John xiv. A collection for defraying incidental expenses will be made.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

THE STETHOSCOPE.

Stethoscope, thou simple tube,
Clarion of the yawning tomb;
Unto me thou seem'st to be
A very trump of doom.

Wielding thee, the grave Physician,
By the trembling patient stands,
Like some deftly-skilled musician,
Strange! the trumpet in his hands.

Whilst the sufferer's eyeball glistens
Full of hope and full of fear,
Quietly he bends and listens
With his quick, accustomed ear.

Waiteth until thou shalt tell
Tidings of the war within—
In the battle and the strife—
Is it death or is it life,
That the fought-for prize shall win?

Sometimes may thy tones impart,
Comfort to the sad at heart.
Oftimes, when thy lips have spoken,
Eyes have wept, and hearts have broken.

ROYAL COLLEGE OF SURGEONS.

VIVA VOCE QUESTIONS.

Mark incisions for removal of breast. What structures would you cut through? What must you be careful to do if removing it for cancer? What vessels would you secure? Mark out the course of the internal mammary artery. What other arteries supply the breast? In what direction would the cicatrix be? How to secure the vessels. What ligatures would you use? Would you wait till all the oozing had stopped before bringing the edges together? What sutures would you use?

How high would the bladder reach if distended? Why cannot the intestines get in front of the bladder? Where would you tap in the supra pubic operation?

How would you perform paracentesis abdominis? Select your instruments. How would you hold the trochar? What precautions would you take before the operation? Would you puncture at once, or do anything first?

Mark the course of the femoral artery? Where would you tie it from choice? Make the subject render his sartorius muscle prominent.

How would you treat necrosis of the clavicle. What would you do with a hydrocele What would you inject? Describe the process of cure. Is inflammation always necessary to the cure of a hydrocele?

How would you amputate a finger between first and second phalanges?

How would you treat hernia testis?

How would you check hæmorrhage from a punctured wound of the palm. What vessel might bleed? Give the course of the palmer arches.

What tumours of the head have you seen? How would you remove a sebaceous tumour?

What tumours of the tongue have yon seen? Are abscesses of the tongue common? Is inflammation of the tongue common? Describe a syphilitic tongue.

How would you remove the tonsil? Why would you cut upwards? How would you stop the hæmorrhage?

How would you treat subcutaneous nævus in the face?

What kinds of cataract are there? What is cataract? What is the pathological difference between hard and soft cataract. Shown a melanotic tumour. What is melanosis? Where does it grow? Does it ever grow internally? Is it malignant or non-malignant?

Name the malignant tumours. How do you diagnose carcinoma in a female breast?

What are causes of retention of urine. Where does stricture occur?

In retention of urine, with gonorrhœa, what would be your treatment?

In extravasation where does the urine get to?

EXTRACTS.

—o—

(*From the Medical Record.*)

THE EVIDENCE IN THE WEST HADDON CASE.—No little surprise is expressed by scientific medical men at the evidence of the expert at the disastrous inquest on Mrs Gulliver, that the alleged heat of a body after death warranted the conclusion that 'a noxious volatile substance had been administered, and had caused death, of which, however, he found no traces.' The result of this statement, made to a village jury whose minds were impressed by the local gossip which had led to exhumation, was a verdict of 'death by poison.' Mrs. Waters, the victim of this verdict, courted death rather than face the fearful ordeal before her. Mr. Rodgers is, we think, bound to state on what grounds he made the reckless assertion which led to such fearful consequences. The substitution of a wild hypothesis for a state of doubt is certainly not in the province of of a chemical expert on oath, in a case involving capital charges. The matter cannot, in the public interest, be allowed to rest in its present position of doubt. The sole test of temperature appears in this case to have been the recollections of an impression conveyed to the hand; and on this subject Dr. A. S. Taylor and Dr. Wilks remark truly: 'The condition of the hand itself may lead to an erroneous impression. If the two hands are of different temperatures, a recently dead body may appear cold to one, and warm to the other.

Dr. August Hermann, senior surgeon to the hospital in Prague, and professor extraordinary of surgery in the University, died of hydrophobia on the 7th ultimo. He had been bitten slightly by a greyhound about six weeks previously.

The Amsterdam Medical Club has agreed on the following tariff of fees from January 1:—For ordinary visits, 2, 1·50, 1, and 0·60 florins; for vaccination, 10, 5, and 3 florins; for subcutaneous injection, 3, 2, 1·50, and 0·75 for visits in the country, in addition to travelling expenses, 5 and 3 florins per hour.

The University of Würzburg is about to receive a valuable addition to its staff in the person of Professor Rindfleisch, of Bonn, the author of a work of high merit on Pathological Anatomy, well known to English readers through its translation by the New Sydenham Society. He has been appointed professor of the subject on which he has so ably written in the above university: and Professor Klebs, who has hitherto held the post, goes to the University of Prague.

LADY DOCTORS IN GREAT BRITAIN.—A considerable step has been made by the King and Queen's College of physicians of Ireland towards the licensing of the practice of midwifery by ladies in this country by a registrable diploma. This college holds a charter, dated 1692, which was especially granted to it for the purpose of examining and licensing midwives, and punishing those who were not licensed. It has, however, in the course of a hundred years, licensed two only, and has used for men exclusively the powers granted in behalf of women. It has now been applied to in behalf of women, and has expressed its willingness to fulfil the terms of its charter, and having passed a resolution admitting the principle, has also appointed 'a committee to report to the college on the qualification and examination to be adopted in the case of candidate midwives, and the form of the diploma to be conferred on them.

HIGH PRICES AND INCREASED MORTALITY.—The effects of the high prices of the necessaries of life are painfully manifested by the Registrar General's Reports: the season has been exceptionally mild, but damp, and to the prevalence of dense fogs has been attributed the high rate of mortality. There is, however, another aspect of the subject deserving serious consideration—to what extent is the increase to be attributed to the necessity for economy in the consumption of fuel? To people residing in the suburbs of London and other large towns, occupying houses, recently built, of porous material, absorbing and retaining a large quantity of moisture, heat is as necessary as food; yet, in the absence of the master of the house, the prudent wife daily allows the fire to die out, and in consequence the family are exposed to all the dangers of damp rooms and attendant evils. Every bed-room should be thoroughly warmed and ventilated by an open fire once at least in each week, and in new houses especially, whenever the walls show any signs of damp; yet now often do we find the moisture running down the walls and staircases when called in to visit patients suffering from bronchial affections? In such cases the best advice to our patient is to ventilate your house and warm your rooms.

PROFESSOR NAMIAS, of Venice, has recently died after a short illness.

FOOTBALL CLUB

—o—

GUY'S I. v. ST. MARY'S

It is impossible to describe the above match, which was played at Blackheath last Saturday, as it consisted in either one of our men, or else a St. Mary's man, touching the ball down behind their goal, but the result was Guy's winning by three goals, eight tries (four of which were punted out),

and innumerable touches to nothing. Team—Robson (captain) ; Breach and Wallis (backs) ; Welchman (three-quarter back) ; Gray and Finch (half backs) ; Gilbert, Wells, Mutch, Collins, Brown, Duke, Elliot, Richardson, and Kerr.

GUY'S II. v. ST. THOMAS'.

The return match between the above hospitals was played last Saturday on Clapham Common, and again resulted in a victory for Guy's, who obtained a goal and two tries to nothing. The first two touchdowns were obtained by Maltby and Gardner, but in both cases the try at goal was unsuccessful. However, shortly afterwards the Guy's back (A. Poland) made a capital run and obtained a touchdown, which Jackson soon converted into a goal. For St. Thomas', Cockell, Davis and Mason especially distinguished themselves, while for Guy's the same may be said of Perry, Reader and Poland. Team—Maltby (captain), Poland, Perry, Jackson, Levien, J. Poland, J. H. Poland, Roberts, Mainwaring, Richards, Steele, Reader, Gardner, Peskett, and Chapman.

ROYAL COLLEGE OF SURGEONS.

Pass Examination for Membership, April, 1874.

MR. RENDLE will COMMENCE his EVENING CLASSES for the above Examination on TUESDAY EVENING, FEBRUARY 17. Gentlemen wishing to join should send in their names at once.
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All communications to be addressed to

The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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Guy's Hospital Gazette.

VOL. III.—NO. 20. SATURDAY, FEBRUARY 14, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

IT is only to be expected, that of a great body of students required to pass a certain examination, as for instance the membership of the Royal College of Surgeons, the greater number would wish that, though admittedly fair, it might still be considerably reduced in severity, to save them the trouble of gaining the necessary amount of knowledge to pass it as it at present stands—the lowest *fair* standard. But it is not to be expected, that this easy going—we might use a harder term—majority should be supported by any organ of the press, more especially the *Student's Journal;* which would have done better to have maintained its place as an able adviser, than to have taken upon itself the position of a complaining student. We have been accustomed to find the leaders of contemporary seasoned with an energy and spirit calculated to improve the tone of the rising medical generation. We remember with pleasure its pungent attacks on Special Hospitals, Quackery, and Spirit-puffing. But the remembrance of these spirited attacks now only serves to show up such spiritless suggestions as, that "a longer paper ranging well over the whole of Surgery" should be substituted for the present. And that for the pass examination "Surgical Anatomy be struck out of the heading of the paper, and that it be confined to the Principles and Practice of Surgery only," at the same time that "it should be impressed on the student" that the science of Anatomy "has a direct bearing upon the science of Surgery." While an objection to a question set on a large class of one of the most important branches of the profession—skin diseases, seems to us a positive absurdity. All those who have recently been students must know, that a few months cramming from the smallest works on "Surgery," with regular attendance at one or two classes and in the wards at the same time is quite sufficient for any man of good ability to pass the membership examination at the College. To reduce this would be to place the College on a footing with those bodies, which enter on a miserable competition with it and the Hall, and are content to swallow their dregs.

LECTURES ON MEDICINE.

BY DR. WILKS.

—o—

(*Continued from page* 147.)

MEASLES.

Measles has an incubation of twelve to fourteen days, when taken in the ordinary manner. If the secretion be inoculated, the first symptoms of the disease appear in a week. The disease approaches with all the usual febrile symptoms, to which are added those of a severe cold or bronchitis. The face is puffy, the nose runs, the eyes are watering, and there is sneezing. The temperature rises to 104 or 105 in from thirty-six to forty-eight hours. After these febrile and catarrhal symptoms have lasted for three days the rash appears. This is first observed about the roots of the hairs at the forehead, and spreads from here to all parts of the body, being full in another day. The temperature, then, is often observed to fall, standing at about two degrees above normal heat during the remainder of the complaint. This loss of fever is a fact well known to mothers and nurses, who are aware that children will often be able to amuse themselves as in health whilst the rash is out. The latter continues for four or five days, and then departs. It differs from that of scarlatina in not being so uniform, but in patches, these being disposed to assume a crescentic form. The colour is not so bright red as that of scarlatina, but is more of a yellowish brown. It is often even darker, and leaving a brown stain for some considerable time after the rash has gone. At the same time as this true exanthem exists there is often associated with it a slight

papular eruption; this is not so frequently noticed as in scarlatina, but it may frequently be observed. When the rash is over, a slight desquamation takes place, but less than that which occurs in scarlatina. The temperature has now fallen to the normal standard. During the progress of the complaint the swelling of face, and catarrh continue. If the case be a mild one the catarrhal symptoms depart with the rash and the child is well.

In bad cases an actual bronchitis occurs, and this amounts to a complication, so that the danger of the disease lies in this lung complication, therefore it is that measles is so rarely fatal amongst the better classes, and is attended by so many dangers amongst the poor. The chest complication becomes in the first place a severe bronchitis, and subsequently a catarrhal or broncho-pneumonia. This is what we find on post-mortem examination, and it is not because broncho or lobular pneumonia is especially a disease of children that this form of inflammation occurs, for the same is found in adults, as we had an opportunity of observing here a few years ago in the case of some sailors; for in those who died a true broncho or lobular pneumonia was found. In the bronchitis of measles very large quantities of purulent matter are expectorated. If not immediately fatal the bronchitis may continue as a chronic affection, and the child wasting he may be thought to be in a consumption, but recovery will shortly take place. In a similar manner a wasting diarrhœa may continue for a lengthened period. Very exceptionally there may follow a nephritis and albuminuria.

Measles is highly contagious by means of the vaporous emanations from the lungs and body. The secretions from the nose are also highly contagious. The cause is generally believed to be a specific animal cell, although it has been suggested by Hallier to be a vegetable germ; in fact, an already recognised fungus.

There are no important varieties. A malignant form is spoken of as occurring in some parts of Europe, but I have never seen it. A variety is sometimes spoken of as black measles, where the rash is remarkably dark. I have on several occasions seen the rash as dark as mahogany, but the disease otherwise was not more severe.

The treatment consists in pure warm air, and cooling drinks.

HYBRID MEASLES.

I ought to inform you that some medical men have regarded scarlatina and measles as varieties of the same disease, since sometimes cases may be met with where the symptoms partake of the nature of the two affections. Others, when meeting with cases of this kind, have considered that they have before them a combination of the two diseases. Others have regarded them as a variety of measles, and others, again. as a variety of scarlatina. The cases are those where sore throat and swelling of the neck are associated with coryza and a rash, having an intermediate character between the two exanthems. A child, for instance is observed to have the puffy face and sneezing of measles, whilst at the same time there exist great injection and redness of the throat, together with a swelling of the glands of the neck. On the third day a rash is apparent on the face, and becomes diffused over the body; this is patchy and red; after four days, followed by desquamation; sometimes dropsy follows. During the disease the throat may be very bad, and there may be pulmonary complications.

There exists, therefore, a disease which in its symptoms partakes of the nature both of scarlatina and measles, having the throat of the former with the coryza of the latter, and a rash which is intermediate in character. I before told you that the test of the specificity of a disease is to be found in its mode of propagation, and therefore we must further ask whether this hybrid disease is found in connection either with pure measles or scarlatina? I believe it is not. I had an opportunity some years ago of seeing examples of this affection, and I noticed that several of the kind occurred in the same house. I am therefore led to believe that we are dealing with a distinct form of exanthem. Those who hold this opinion would style it "rubeola" or "rugeole," and so distinguish it from scarlet fever and measles, which would then be technically called "scarlatina" and "morbilli."

PHYSICAL SOCIETY.

The eighth meeting of this session took place last Saturday, Mr. F. J. Morton Palmer was in the chair, and Mr. Snook read a paper on "Puerperal Convulsions."

Mr. Snook called attention to the discrepancy there existed among authors as to the nosology of puerperal convulsions, adverse terms being used by them. In proceeding, he thought eclampsia was not to be applied to all cases, as to apoplectic fits consequent on long labour. He did not think that emotion, or even anything likely to effect excito-motor action would cause it unless the excited nerve centres were badly influenced by some blood dyscrasia, and had lost their power of control. He thought post-mortem statistics and the seldom occurrence of paralysis in those cases which occurred quite enough to exclude Ramsbottom's teaching—that puerperal eclampsia was apoplexy. He would divide puerperal convulsions into two classes—those cases which occurred casually during the puerperal stage, and those which required the puerperal dyscrasia for their origin. In describing a marked case of true puerperal convulsions met with in the "Charity," he drew attention to the relation between sensibility of the retinia—which was as follows—and asked whether the same thing occurred in epilepsy:—

In first stage of fit—pupil dilated—conjunctivæ insensible;
in second ditto —contracted— ditto insensible;
in third ditto —contracted— ditto sensible;

so that the conjunctivæ were affected before the contraction of the pupil. He thought the ammonia theory corroborated by the experiments of Oppler and Spiegelberg, and that the ammoniacal intoxication resulted in both coma and convulsion. Again, that puerperal eclampsia was not a distinct disease from epilepsy, but a modification of it, the difference being dependent on the peculiar condition of the system, and that an anæmic rather than hyperæmic cause was pretty well proved by Küssmaul and Turner—that it did not matter whether the inanition of the nerve centres was caused by the peculiar nature of the blood or mechanical obstruction, provided proper arterialised blood be cut off. As the premonitory symptoms were often hidden, he recommended Dr. Rees process for early detection of albuminuria; it having been detected, colchium might be given to get rid of urea, but this should be done chiefly by the bowels and skin—that the latter might be used as an eliminating organ in this way was proved by Bazingsky's experiments. Again, crystals of urea were found on a man's forehead at p.m. He referred

to the illustration of venesection, as compared with chloroform treatment in Guy's Hospital Reports, by the late Dr. Phillips, the statistics showing great decrease in mortality since anæsthesia was used—at present 35 per cent. He thought, however, that the good of the anæsthetic might be somewhat neutralised by the bad results of the chloroform if kept up indefinitely, as the dominant fact in its physiological effect is want of supply of arterialised blood, and referred to a 72-hour labour, in which the os would not yield to surgical or medical treatment, and suggested the use of an instrument (dilator), which might be applied, notwithstanding the head being kept tight against the rigid os. In such cases Dr. Barnes's Bags being inapplicable.

Mr. Day thanked Mr. Snook for his exhaustive paper. Mr. Snook had described his case as one of apoplectic convulsions; now this could hardly be its true pathology, since there was a return of consciousness between the fits. He thought that the author too readily jumped at the conclusion that chronic Bright's disease was present in these cases, a little œdema of the legs did not necessarily show that there was albuminuria, granular kidneys, and all that sort of thing. He would advise that premature labour be induced in all cases, and under the influence of chloroform.

Mr. Hicks thought that we had to thank Guy's for the advance in knowledge of Bright's disease, and certainly in puerperal convulsions. Mr. Snook, he was sorry to find, had discarded the views taught here for those bred in Germany, and which were easily shown to be unreliable; for instance, if we examine in a number of cases the urine before the convulsions set in, we find in nearly all that it contains no albumen: but when the convulsions occur, albumen often appears in quantity, showing that the Bright's disease is the consequence, and not the cause, of the convulsions. He thought that the people who held the German view, namely, that the convulsions were due to the conversion of urea contained in the blood into carbonate of ammonia, had got into a muddle, and he narrated experiments, which in his opinion, completely "squashed" such an idea. He was glad that Richardson and Frerich's had given up this view, and he gave proof that, at least in many cases, the convulsions were due to irritation of the nerves of the uterus. He considered the condition of the pupil of no value whatever. And he hoped that Mr. Snook's advice, to let the mother die and save the child by Cæsarian section, would not be adopted by any one.

Mr. Paul believed some of the details of a case of puerperal convulsions, which had recently occurred in the "Charity" would be of interest to the members. The facts were these—the other night Mr. Williams had been summoned by an extern to a woman, who was evidently very ill, and had convulsions. Upon his arrival he found that the case was one of a young woman of full habit, in her third confinement, the other two having been normal. She had enjoyed good health previously, and nothing had gone wrong until the second stage of labour when the convulsions set in, which were now very severe, teeth clenched, face and eyes suffused, limbs rigid, and bloody froth issuing from the mouth. When he, Mr. Paul, arrived the patient was quite unconscious—she had been so since the first convulsion—conjunctivæ insensible, pupils, contrary to Mr. Snook's case, dilated, body rigid but not convulsed, breathing forced, and the os fully dilated. There could be no doubt that labour should be completed without delay, he therefore extracted the child with the long forceps under chloroform. Bleeding was considered, but as was expected, sufficient blood was lost after delivery. As the effects of the chloroform passed off, the limbs again became rigid and the breathing difficult, till at last it ceased. The child lived. He thought Mr. Snook wrong to quarrel with the term eclampsia, since it helped to keep this disease separate from true epilepsy. He understood both Mr. Hicks and Mr. Snook to imply that albuminuria and nephritis were synonymous.

Mr. A. H. Jones thought that there was not sufficient proof to show that puerperal convulsions were due to the conversion of urea in the blood into carbonate of ammonia, for, in the first place, it was not settled that the presence of carbonate of ammonia in the blood was sufficient to cause convulsions, nor was it in any way proved, that urea would undergo conversion into carbonate of ammonia in the living subject. Mr. Hicks had misunderstood Mr. Snook; the latter recommended premature delivery, and not that we should wait for Cæsarian section. He agreed with Mr. Paul that post partum hæmorrhage must be considered with reference to venesection.

Mr. W. H. Lamb thought Mr. Jones' remarks tended rather to prove the carbonate of ammonia theory, for he allowed the presence of urea, which *might* become converted into carbonate of ammonia, which *might* set up convulsions. Albumen was not present in the urine in all cases, but then urea might be retained without albuminuria. Frerichs had shown that the presence of sugar prevented the conversion of urea into carbonate of ammonia. Chloroform acts in a similar manner, and thus it appeared, that the beneficial action of chloroform in puerperal convulsions might arise from this property. Mr. Snook recommended the hot-air bath when Bright's disease was present, but lately in the Hospital a patient suffering from chronic Bright's disease was ordered hot air baths; he was evidently worse after the first, and whilst having the second his lower limbs became paralysed, and he shortly died. He quoted some statistics in puerperal convulsions, showing that epilepsy did not predispose to this condition.

Mr. Fry remarked that Mr. Snook would have us believe that puerperal convulsions are always due to uræmia. This he could not accept; nor, on the other hand, could he agree with Mr. Hicks, that there never was albuminuria before the convulsions. It seemed to him that some cases were the result of uræmic poisoning, and others of irritation of the nerves of the uterus. Mr. Lamb said that epilepsy did not predispose to puerperal convulsions; he quoted statistics to show that this statement was wrong.

Mr. Green had associated puerperal convulsions with epilepsy, but had noticed that the latter was much more liable to recur than the former. He had been at a loss to account for this, until he heard Mr. Paul consider them as separate diseases. It seemed to him an important fact to be able to decide, that when a primipara had convulsions were they likely to recur? He thought that convulsions in primiparæ were often of a milder form, perhaps caused by the excessive pain and associated with hysteria, quite different from the severe form less frequently met with. He wished Mr. Snook had gone into the difference between puerperal convulsions in primiparæ and multiparæ. He would also like to know whether it was usual for the child to have convulsions.

Mr. Lancaster did not believe in the view propagated by some that albuminuria was due to direct pressure on the kidneys, and thought it much more probable that it was due to pressure on the renal veins. The convulsions he thought were usually due to irritation of the nerves of the uterus.

Mr. Turner was also of opinion that the convulsions were in the first place due to irritation of the nerves of the uterus, but it seemed to him that they, by impairment of the functions of the kidneys, might lead to retention of

urea in the blood, and thus secondarily be brought about by uræmia; so accounting for a continuance of the symptoms after the source of the uterine irritation had been removed.

Mr. Day thought it well to mention that Dr. Thudichum believed that the convulsions were due to the colouring matter, rather than the urea.

Mr. Turner said it was more probable that the noxious substance in the blood would be matter which would have been converted into urea, rather than urea itself. The convulsions being due rather to a failure of kidney function, than to re-absorption of urinary ingredients.

Mr. A. H. Jones thought that if they were due to the non-formation of urea, we ought to be able to decide the question by discovering in the blood those chemical substances which go to form urea.

Mr. Williams remarked that in renal disease before a state of uræmia ever occurred the diseese was far advanced and he could not imagine a case of extreme morbus Brightii in which some of its features were not apparent without going into the history. In the case which had recently occurred in the "Charity," there was no appearance of this disease, and the woman had passed water normally up till just before she got there, therefore he could not think that she was suffering from renal disease. He noticed in this case, that every time he made a vaginal examination, and he made two or three, severe convulsions were set up, leaving no doubt in his mind, that in this case at least the convulsions were due to some condition of the uterus.

Mr. Cock regretted that more had not been said of puerperal convulsions occurring some time before labour set in. He thought this a point of greater interest to those expecting to practice shortly. He recommended premature labour, as the convulsions frequently subsided altogether after delivery. The old plan of treatment was calomel, bleeding, and blisters to the nape of the neck.

Mr. Waterhouse agreed with Mr. Turner that it was more probable that the substance going to form urea, than urea itself would be the irritant matter. He narrated a case of puerperal convulsions.

Mr. M'Carthy pointed out that besides the kidneys and the renal veins, either the renal arteries, or the ureters might be pressed upon.

Mr. Lancaster observed that the arteries lay behind the veins, and from their stronger blood cnrrent were less likely to be compressed.

The President then called upon Mr. Snook to answer the remarks upon his paper; this having been accomplished with some prolixity, Mr. Harsant proposed, and Mr. Paul seconded, a vote of thanks to Mr. Snook for his able paper.

The President announced that Mr. W. H. Lamb would read a paper on "Temperature with reference to Disease," at the next meeting, February 21st, 1874.

The meeting then adjourned.

MEDICAL WARDS.

The following cases were admitted from Feb. 5 to Feb. 11, 1874.

MIRIAM (Clinical).

18—Right Hemiplegia, with Aphasia
23—Abdominal Tumour, malignant
31—Heart Disease, Aortic

JOHN (Clinical)

No Admissions.

PHILIP

22—Hemiplegia
28—Bronchitis—Dilated Heart
35—Chronic Pleuro-pneumonia

STEPHEN.

2—Cerebral
5—Bright's Disease
21—Bright's Disease
27—Dilated Stomach
46—Bright's Disease
49—Mental Depression

MARY.

1—Eczema of Face
12—Syphilis

ADDISON.

5—Rheumatism
11—Hysteria
15—Hysterical Epilepsy
16—Eczema
31—Chronic Rheumatism
36—Heart Disease, Mitral

ASTLEY COOPER

10—Acute Bright's Disease
19—Acute Rheumatism
12—Œdema of Leg

SURGICAL WARDS.

The following cases were admitted from Feb. 5 to Feb. 11, 1874.

ACCIDENT.

2—Fracture of Tibia and Fibula
3—Fracture of Patella
4—Fracture of both Tibiæ
5—Practure of Tibia and Fibula
6—Fracture of Tibia and Fibula
12—Fracture of Fibula
15—Compound Fracture of Tibia and Fibula—Amputation through Knee-joint
18—Fracture of Fibula
21—Contusions of Back
28—Compound Fracture of Tibia and Fibula—Amputation through Knee-joint
32—Fracture of Fibula

CORNELIUS.

1—Scalp Wound—Concussion
5—Fracture of Fibula
13—Compound Comminuted Fracture of Skull—Trephining
16—Injury to Abdomen—Ruptured Brachial Artery (right)
20—Injury to Thorax—Pneumo-thorax (left)

LYDIA

8—Strangulated Femoral Hernia—Death
8—Contusions to Shoulder
9—Femoral Hernia—Strangulated—Operation
10—Burns—Death
14—Disease of Hip
16—Disease of Ankle-joint—Amputation of Leg
21—Burns—Death
23—Disease of Knee-joint and Lumbar Spine
24—Suppuration External to Knee-joint
25—Fracture of Tibia
27—Œdema Glottidis from swallowing hot water—Tracheotomy

MARTHA

No admission.

JOB.

16—Fracture of Tibia and Fibula
19—Fracture of Tibia and Fibula
20—Tumour of Shoulder
24—Disease of Hip

LAZARUS.

6—Ulcer of Leg
22—Stricture—Perinæal Fistula

LUKE

11—Stricture
19—Exostosis from outer Surface of Tibia

NAAMAN.

2—Old Dislocation of Shoulder
4—Inflammatory condition of Larynx—Old Thickening of Epiglottis
6—Epithelioma of Tongue
9—Tumour of the Chest
22—Stricture

CHARITY

4—Stiff Ankle-joint from old Ulceration
26—Spinal Disease

RUTH (Ophthalmic)

28—Corneo Iritis
31—Corneo Iritis
32—Retinitis

BARNABAS (Ophthalmic)

3—Cataract
14—Corneo Iritis
17—Closed Pupils

STATISTICS OF THE SURGERY.

JANUARY, 1874.

MALE SURGERY.

Teeth extracted		114
Contusions and Sprains		210
Wounds		107
Fractures—		
Ribs	12	
Clavicle	4	
Humerus	4	
Olecranon	4	
Acromion	1	
Radius and Ulna	5	
Radius and Ulna (compound)	2	
Radius	3	
Metacarpal bones	3	
Phalanges	5	
Phalanges (compound)	12	
	—	55
Dislocations—		
Humerus (Subcoracoid)...	5	
Humerus (Axillary)	1	
Jaw (?)	1	
	—	7
Burns and Scalds		9
Bites		11
Foreign bodies in Eye		9
Retention of Urine		9
Abscess		17
Synovitis		6
Gonorrhœae Orchitis		4
Paraphymosis (reduced)		1
Hydrocele (tapped)		7
Hernia (reduced)		3
Bleeding Varicose Vein		1
Epistaxis (Posterior nares plugged)		2
Medical		22
Mussel poisoning		2
Unclassified cases		71
Total number of patients ...		667

FEMALE SURGERY.

Teeth extracted		123
Contusions and Sprains		61
Wounds		14
Fractures—		
Ribs	6	
Clavicle	1	
Humerus	1	
Olecranon	1	
Radius	2	
Metacarpal bones	1	
Phalanges	1	
Fibula	1	
	—	14
Dislocation (Thumb)		1
Burns and scalds		5
Bites		2
Foreign bodies in Throat		2
Foreign bodies in Ear		1
Fish bone in Rectum		1
Retention of Urine		3
Abscess		7
Children Tongue-tied		6

Paraphymosis	...	..	...	...	1
Needle in Leg	...	...	...	...	1
Medical	...	...	...	...	6
Total number of patients				...	248

Total number of patients attended to in both Surgeries—915

H. HETLEY,

Junior House Surgeon.

ROYAL COLLEGE OF SURGEONS.

VIVA VOCE QUESTIONS.

Practical Surgery.

Mark out the Axillary Artery on this man. What is in front of it? How many parts is it divided into, and what marks out that division? Which part has the Pectoral Minor in front of it? What is in relation with that part besides? Is there any nerve that passes across it in its first part? What nerve passes behind it? If the Pectoral Muscles were removed would the artery be exposed in the whole of its course? What pierces the Costo-coracoid Membrane? Put your finger on the head of the Radius. Apply a Spica Bandage.

Instruments. What instrument would you use for sounding the Bladder? Why one with a short curve? Trephining—how would you use it? Apply it to this skull. Tonsil Guillotine—how would you use it? Instruments for puncturing the Bladder per rectum shown. Bellocq's sound and a skull given to pass it.

Clinical Surgery.

1. Boy with Phymosis and Syphilitic rash on body. What would be your treatment?

2. Hernia Testis. What is that mass composed of? What treatment? What might it be mistaken for? What kinds of malignant disease? What is the thickening about the Penis due to? [Answer required—Deposit of fibrin.]

3. Necrosis of Tibia. Operation—bone had been removed. What was the state of the cavity from which it was taken? What the state of sequestrum. Is there any dead bone there now? If so, why? What was the cause? [Answer required—Periostitis.)

4. Man with Syphilis, a large sore on Penis, also Psoriasis on body? What would be treatment in such a case? [Answer required—Not to give mercury unless the sore had healed.)

Pathology.

Hypertrophy of Bladder and middle lobe of Prostate. What symptoms might such a condition give rise to? Why frequent micturition? How diagnose it? Do you think you could have felt that Prostate per Rectum? Why pass a full-sized catheter? What is the difference in the hypertrophy of the structures? Plug in an artery—what do you you call it? What do you call a plug in a vein? What are the causes of inflammation of veins? What symptoms does it give rise to? Fracture of Patella (transverse)—how do you treat such a case? Do you think that a good result? Do you ever get bony union in such a case? How long would you keep it up in the splint?

Fracture through the shaft of Femur. A bad result. How treat such a case? Where is the extension applied in a double-inclined plane? Why treat it so? In fracture of Tibia, what often causes it to become compound? In a compound fracture of Tibia, and patient bleeding a wine glassfull of blood in twenty-four hours, how would you treat it? If bleeding more, what would you be inclined to do? How would you know if any important vessel was injured?

Hydrocele. How would you treat it in children? Why not tap? How treat it in an old man? How treat it in a young man? What is the radical cure? What is the strength of the iodine you would use? Would you leave it in or not? What takes place in the sac after the iodine has been injected, the next day, and in a week?

APOTHECARIES' HALL.

At an Examination held on the 13th inst., Messrs. G. Power and H. N. Smith were admitted Licentiates.

The questions will be given next week,

FOOTBALL CLUB.

GUY'S I. v. ST. THOMAS'.

This match played on our gounds last Suturday, resulted in a draw slightly in our favor by three touchdowns to nothing. We were disappointed in two or three of our men, and played one short for the first (and we hope the last) time this season. It will be remembered that St. Thomas put off the first match, at the beginning of this season. Our football readers will be sorry to hear that the Richmond Club will be unable to play a return match with us, on account of their list of engagement being full. The team that played was:—W. W. Pinching (captain), Gilbert, Wells, Rendall, H. Duke, Hetley, Mutch, Collins, Brown; Robson and Breach (backs), Gibb (three-quarter back); Lyson and Finch (half backs).

GUY'S II. v. WIMBLEDON SCHOOL.

This match was played last Saturday on Wimbledon Common, and after a very hotly and contested game, ended in a draw. The Guy's team all played up well. Guy's:—Mutch (captain); Poland and Jackson (backs); Richardson,

Johnson, Smart, Duke, Reader, Roberts, Mainwaring, Levien, Perry, Jumeaux, J. Poland, Richards.

MATCH THIS DAY.

Guy's I. *v.* University College (return), at Blackheath.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

ROYAL COLLEGE OF SURGEONS.

Pass Examination for Membership, April, 1874.

MR. RENDLE will COMMENCE his EVENING CLASSES for the above Examination on TUESDAY EVENING, FEBRUARY 17. Gentlemen wishing to join should send in their names at once. 4, Finsbury Square, E.C.

VOLUME I, of "Guy's Hospital Gazette," from October 1, 1872, to April 26, 1873; all the numbers are very clean; price 10s.—Address, at the Publisher's, 104, Borough High Street.

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All communications to be addressed to

The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

And should be posted (prepaid), or left at the Porter's Lodge.

All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

We reserve the right of omitting any communications that may be received by us.

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Session GUY'S HOSPITAL. 1873 and 1874.

To Gentlemen about entering at the above Hospital.

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Guy's

Hospital Gazette.

VOL. III.—NO. 21. SATURDAY, FEBRUARY 21, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE.

We have been asked by the Presidents of the Physical Society to remind the competitors for their prizes, that they have but one week left in which to complete their essays; for none will be received after the first of March. We were pleased to receive this notice from the Presidents, for it seemed to show that they evidently expected some competition, a subject upon which we had felt very considerable doubt. Already we have felt it our duty to censure the third and fourth years' men for their lack of energy in offering papers to be read before the society. Indeed we have come to the conclusion that the Presidents would do better to add their handsome prizes to the Samaritan Fund, than to take the trouble to goad such lazy, spiritless students into competition for honour and gifts, which they seem equally unable to appreciate. When the vast number of students are considered to whom these prizes are open, it is indeed a sad reflexion to discover that only six or eight can be found to try for them. It is just possible that we are mistaken in our estimate of these students. On the 1st March a good number of essays for the prizes may be received. We earnestly hope that such may be the case. We wish it to be proved that we are altogether wrong. It remains for the third and fourth years' men to decide whether next week we corroborate or apologise for our poor opinion of them.

Dr. Galabin has been appointed Assistant Obstetric Physician, to fill the vacancy caused by the death of the late Dr. J. J. Phillips.

Dr. Savage, of Bethlehem Hospital, has been appointed Lecturer on Mental Diseases, in the place of the late Dr. Thompson Dickson.

Mr. Hinton has kindly placed in the hands of the Librarian copies of his Introductory Address, with additions, which may be had by the students on application.

Not being in the receipt of any original valentine to commemorate the 14th, we reprint one of Albert Smith's, written more than thirty years ago, in order to show the vast improvement which has taken place in the manners and customs of the medical student of the present day, to say nothing of his superior knowledge of the nerve-supply to the muscles of the face.

THE MEDICAL STUDENT.

Son of the Scalpel! from whatever class
You grind instruction, just enough to pass
St. George's, Guy's, North London, or King's College,
Thirsting alike for half-and-half and knowledge.
Thou who must know so well (all gibes apart)
The true internal structures of the heart—
This heart—which you "a hollow muscle" call,
I offer thee—aorta, valves, and all.

Though to cheap hats and boots thy funds incline,
And light rough Chesterfields at one-pound-nine,
Though on the virtues of all plants thou'rt dumb,
Save the *Nicotiana Tabacum*.
(Pentandria digynia! Lindley-mum!)
Though thou eschewest the hospital's dull gloom,
Except to chat in the house-surgeon's room,
And practically practise, in addition,
The "Physiology of Deglutition."
Yet much I love thee, and devoutly swear,
With lips that move controlled by the "fifth pair,"
That I will ne'er know peace until our hands
Shall form a "ganglion" with Hymen's bands.

Then haste, my love, and let me call thee mine,
Precious and dear as sulphate of quinine,
Sparkling and bright as antimonial wine,
Sharp as the angles of a new trephine,
My reckless, noisy, fearnought Valentine.

LECTURES ON MEDICINE.

BY DR. WILKS.

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(*Continued from page* 154.)

SMALL-POX.

Small pox is a specific contagious disease, commencing with febrile disturbance, and more especially with sickness, headache and pain in the back, followed on the third day by an eruption of pimples, which inflame and suppurate, accompanied by some similar eruption of the mucous membrane of the mouth.

Incubation.—Average time is twelve days, never longer than a fortnight, and never been observed less than ten days. When the variolus matter is introduced by inoculation, the system is affected in eight days; during this time the pustule is forming and when quite mature constitutional symptoms ensue and the general eruption appears.

The *initiatory fever* is often marked by the symptoms above-named, and therefore the nature of the disease is at once suggested; I refer more especially to the sickness and pain in the back. The latter often is so great that it constitutes the patients' principle trouble, and has been the cause of his seeking medical advice. In children there is often delirium and convulsions.

Premonitory rash.—Not uncommonly a general roseolous rash precedes the true variolous eruption; this is a true exanthem, and may mislead you as to the nature of the approaching diaorder. In some malignant forms of the disease, as well as in mild ones where persons have been protected by vaccination, this rose rash may be the only cutaneous evidence of the existence of small-pox.

The roselous rash if it has been present soon subsides, and makes way for the true eruption. This appears first as a number of papules scattered over the body; they are seen first on the face, or perhaps about the same time on the wrists or backs of the hands, and then spread. Before the eye can perceive them they may be felt by the hand as if grains of sand were scattered over the surface. These papules enlarge, then some fluid is seen within them constituting them vesicles; afterwards this becomes opaque, and they are styled pustules. It takes eight days for the pustule to form, and this is called the period of "maturation." These pustules are about the size of a pea, and may cover the body in more or less degrees. When scattered and separate they yet have a tendency to form in groups of four or five together. The pustule is round, and depressed or umbilicated in the centre, which is characteristic of the disease. Most vesicles or pustules, as you know, are acuminated, but the variolus pustule is depressed in the centre. This seems to be due to the inflammatory products being formed around a hair follicle, with its sebaceous glands, and in the case of the palm of the hand at those points in the skin which would correspond to the site of these structures; consequently, instead of the secretion, which is formed from the rete mucosum, simply raising up the cuticle in a pyramidal shape, it is confined in a circular space around a point where the cuticle still remains attached to the cutis beneath. This string of attachment is called the stigma. The formation of the variolous pustule is not much unlike that of the vaccine-vesicle, and therefore you may get an idea of its structure from a knowledge of the latter. You know that in obtaining matter from this, you have to prick the vesicle all around, as the fluid is contained in separate chambers, and you know also how this is shown in the cicatrix which is left. A vaccine scar being circular, somewhat depressed, radiated and foveated, that is, marked with minute pits. Now, the small-pox pustule has much the same formation, it is not really divided into separate chambers, although the mode in which it is developed has a tendency to separate the secretion into portions. Thus, there is formed from the rete mucosum a softish layer of lymph, and this being raised at the sides whilst it is held down in the middle, a number of almost distinct spaces are formed by the folds and corresponding chambers between them. This umbilicated pustule is mature in eight days: it then changes its colour, turns yellow with a faint redness around the margin; it becomes, then, brown, with a distinct red halo around, the filamentous attachment or stigma gives way, and the pustule discharges itself, which, together with the broken pustule, form scabs on the surface. These eventually fall off, leaving reddish stains or pits.

I have said that at the onset of variola the febrile symptoms run high, and thus on the third day the temperature may be observed as high as 105 deg., but afterwards it falls and for two or three days before maturation is complete, the temperature has fallen to normal, at which point it is found on the eighth, ninth, and tenth day. Now, after this there is a second accession of fever, and herein you will observe a difference between variola and other exanthemata. It is like them in the fact of the subsidence of fever with the development of rash, but in them the eruption is no more than an exanthem, whilst in small pox there is an actual inflammation of the skin, which in itself is productive of symptoms. Thus, as soon as the pustules are matured, and inflammation occurs around them they burst, and the process is accompanied by the secondary fever, and a rise of temperature to 104 deg. about the fourteenth day. This remains for two or three days, when it again declines and the patient is convalescent.

During the progress of the disease pustules may be observed on the tongue and inside of the mouth. The whole of the mucous membrane is much injected. At the same time there is a similar condition of the bronchial passages, with secretion from them. The eyelids swollen, and conjunctivæ inflamed. There is often delirium at night, and other symptoms already described as accompanying the fever of the exanthemata. The danger depends upon the virulence of the poison and the amount of the rash, also upon the amount of pulmonary obstruction. You may remember that we divide a case of small-pox into four stages—that of incubation lasting twelve days, the eruptive fever lasting two days, that of maturation eight days, and the secondary fever three or four days.

Dr. Gregory, the physician to the Small-pox Hospital, was in the habit of dividing small-pox into the following varieties:—1. Variola Discreta, 2. V. Confluens, 3. V. Semiconfluens, 4. V. Corymbosa, 5. V. Benigna, 6. V. Maligna, 7. V. Anomala.

The *first* form is that when the pustules are distinct, so that they can be counted.

The *confluent* form is when the pustules on the face and some other pats of the body are liable to run together; and this, excepting the malignant form, is the most fatal variety, as half the patients suffering from it die. As regards the face the pustules coalesce, so that it presents one whitish shapeless mass, like a bladder of lard, and it is only by careful attention that the outlines of the different pustules are seen. Death often occurs before pustulation is complete, and therefore the central depression is often not well-marked. The disease is rarely confluent over the whole body, the

coalescence occurring on the face and parts of the limbs. There is generally sore throat, and much swelling of the neck externally. The inside of the mouth and tongue is also covered, causing much difficulty in swallowing, and the larynx and bronchial tubes are covered with secretion. In all cases of small-pox there is usually a very peculiar and disagreeable odour given off, but in the confluent form the fœtor is horrible. In these cases the cellular membrane may become affected as well as the true skin. The blindness which so often follows small-pox is not from the formation of pustules on the eye, but from conjunctivitis going on to inflammation of the deeper structures.

The *third* form carries its meaning.

The *fourth* form I have never seen, but it was said to constitute a very fatal variety at a former period; it was the case where the pustules were arranged in distinct clusters on the body.

The *fifth* form was the mild form occurring after vaccination, and the *seventh* was small pox in combination with other diseases.

The *sixth* form, the *malignant*, or black small pox, is the most important and fatal of all forms of small pox; it occurred extensively during the late epidemic in England, and I unfortunately saw many cases of it. I have already said that in nearly all these specific diseases, for some reason, generally believed to be due to the great concentration of the poison, it will act so suddenly and violently on the system that it seems to destroy at once the vitality of the blood. This becomes quickly corrupt, it bursts forth from all parts of the body, and death soon ensues. This is eminently the case in small-pox. There may be the usual premonitory fever, and then perhaps a roselous rash appears. This especially on the face, hands, and feet becomes of a dark purple colour, the pulse fades away, death ensues, and the only evidence of small-pox is the history, as far as it has reached, and the concomitant circumstances. In other cases some papules appear, and here and there a vesicle which is beginning to show its umbilicated form; these papules and vesicles become of a black colour; and large purple patches extend over the skin. The face is swollen and purple, the eyes bloodshot, and blood oozes from the mouth. Blood may also pass from the bowels and kidneys. It is a remarkable circumstance, which is so different from what is observed in typhus and some other disorders, that the mind of the patient is perfectly clear. It is always fatal, and long before the pustulation is complete.

On post-mortem examination in these cases nothing more is found than would happen with a dissolution of the blood. In ordinary and discrete small pox pustules are found in the mouth and pharynx, but I am not aware that they exist down the alimentary canal. There may be found bronchitis, pneumonia, or pleurisy, and it is through the chest that death usually occurs in the simpler forms of the disease.

Contagion.—The disease is highly contagious; the vaporous emanations from the lungs and skin carrying the virus. The pustular secretions contain it as well as the dried scabs. It is also infectious before the eruption appears, during the time of the initiatory fever. In the late epidemic a patient with small pox was admitted unwittingly into one of the London hospitals, and the bed clothes becoming mixed with other linen the disease spread rapidly through the institution.

Treatment.—A large, airy room, cooling drinks, and good nourishment. In the worst forms stimulants, as brandy and egg. If the patient is restless and sleepless an opiate is very useful. Various remedies have been suggested as modifying or averting the disease, such as saracena, strychnia, &c., but hitherto have been used without success. Since it is evident that the danger is to a certain extent proportional to the amount of pustulation, and since the latter is greater on the face, hands, and exposed parts of the body it has been thought that the development of the pustules is favoured by the influence of light, and therefore that this would be retarded were the patient placed in the dark. This has been done, and it is said with success; in patients shut up in an absolutely dark room, the extreme pustulation has been prevented, and the accompanying symptoms reduced in severity. It has also been thought that if the pustulation can be retarded by other as local means that it would be beneficial, and thus in the Paris Hopitals the nurses often prick the pustules, and insert within each of them a point of nitrate of silver. Then, also, at different times various applications, as mercurial ointment, have been used, and of late years a layer of gutta percha dissolved in chloroform. I have adopted this plan with no marked success. We are usually content to apply a little oil, in order to counteract the unpleasantness of the scabbing and drying process.

CLINICAL LECTURE.

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ON OLD AND RECENT DISLOCATIONS OF THE HIP-JOINT.

BY A. E. DURHAM, F.R.C.S.

Gentlemen,—I am fortunate in having a very considerable number of good cases from which to select for my Clinical Lectures; so many, in fact, equally worthy of your attention, that I had some difficulty in choosing from them the following cases of dislocation of the hip-joint, which may, I believe, with advantage be brought before your notice. The case of greatest interest, and which I therefore propose to discuss somewhat fully, is an old dislocation of the hip occurring in a man æt. 27, who was admitted into Naaman Ward last May, and which was reduced under chloroform after five months' dislocation. He was a man of fairly strong build, and good health. Towards the end of 1869 he had an accident, and you will please to bear in mind this accident, as it in some measure influences his present deformity, an accident severing, as he says, some of the leaders of his right leg, and causing him to be laid up seven weeks. The injury affected the ankle-joint, which, as you will shortly see, is still swollen and slightly displaced. He became quite well again, and met with no further trouble till May, 1871, when he had a severe fall and was considerably hurt, but again recovering continued his work. Eighteen weeks before admission he fell a distance of eight yards down a stone quarry. When picked up he was almost unconscious, and cannot state positively whether the right hip was in its proper position at the time. He was a good deal injured and completely disabled, so he consulted a medical man and a bone-setter. The medical man said that he had sustained some injury to the hip. The bone setter that he had put his knee out. The latter was wrong, and I may tell you that in a question between a medical man and a bone-setter the bone-setter usually is wrong, but the public put more faith in them, so the man had his knee put in by the bone-setter, but of course without deriving any benefit from the operation. So after a time he went into

the hospital in the district where he lived, and Mr. Brumwell, recently a student here, discovering an injury to the hip sent him to me. He was admitted May 15th, 1873, his right femur having been dislocated just eighteen weeks. The condition of the limb is described as follows in the report taken at the time :—

He lies with the whole limb extremely invented. The pelvis is tilted upwards on the right side for ½in. The knee rests upon its fellow 3in. above its joint. Almost directly backwards from the anterior spine (5in.) is a bold prominence of bone, somewhat like the trochanter major, and from which bone extends downwards to the normal position of the trochanter for 4in. The bone in this part feels very much thickened in all directions. On the left side the trochanter is 5½in. from the anterior spine in its normal oblique direction. On moving the limb the range of motion at the head without lifting the pelvis is from 135 to 155 deg., the limb moves freely in this range without pain, and the prominence of bone moves with the lower part of the femur. Directly backwards from the trochanter a distanee of 3in. is a roundish prominence of bone, which moves with the femur. This prominence we were enabled to decide, owing to the wasting of the muscles that had taken place, was the head of the bone situated on the dorsum ilii just at the upper margin of the sacro sciatic notch, not in the notch itself. I have no doubt that when recent the head of the bone occupied the most usual position higher up on the dorsum ilii, and then caused more shortening; but had since sunk down to the margin of the sciatic notch from the wasting of the muscles. This, then, was the condition he presented when admitted into the hospital more than four months after the accident. The appearances are well shown in the drawing, which was accurately made at the time. Was it right after such a lapse of time to attempt reduction? To answer such a question one usually consults the authorities, and is guided by their experience. In this case, however, I was not guided by the authorities, but by the patient's condition. He was young and healthy, but quite disabled. He suffered constant pain, and was without the power to earn his living. I thought that if the attempt to reduce an old dislocation were justifiable in any case, it was so in this, and in this opinion I was corroborated by my recent colleague Mr. Cock.

On the 6th of June, chloroform was administered until he was completely under its influence, for, contrary to the advice of many authorities, I recommend that chloroform should be administered to its full extent for the reduction of dislocations. It was now nearly five months since the injury, for we had waited for a short time until drawings and photographs had been made. As I have said he was put fully under the influence of chloroform, and grasping the limb at the ankle with one hand, and the knee with the other, I proceeded to move it about in various directions, using the leverage of the limb. This was done carefully and steadily first in one direction then in another, and with my hands I could feel the adhesions breaking down. This flexing and extending, adducting and abducting was not performed with any idea of reducing the dislocation. It was only intended to break down the numerous adhesions which had formed about the head of the bone, retaining it in its abnormal position. Also to try and restore the opening in the capsule by which the bone had escaped, and to stretch the muscles about the joint, which had become converted into a semi-fibrous material.

This having been done the state of things was in great measure reduced to the circumstances of a recent dislocation, and consequently I proceeded as though that were the case. First, flexing the thigh upon the pelvis and somewhat adducting it, then rotating it outwards and quickly extending the limb. This, however, did not entirely mend the position, therefore the process was repeated with some additional traction on the limb, and it was found upon measurement that its length was nearly equal to its fellow, while the deformities indicating the dislocation had disappeared. A long outside splint with footpiece was applied, and the patient put to bed. Of course in a dislocation of long standing the recovery must be proportionally slow. A quantity of fibrinous material is thrown out about the injured parts which becomes converted into strong fibrous adhesions, while in the acetabulum the cartilage disappears and granulations spring up filling the cavity with new material, and at the same time the cartilage of the head of the bone may become eroded and the head itself adherent to the surrounding structures. So that a great deal of repair is necessary, for beyond the healing of the torn structures, the cavity of the acetabulum has to be restored by the pressure of the head leading to absorption of the new material with which it becomes filled. We were satisfied that the limb was in good position, and therefore determined to leave it at least three months in the splint just as it was. After the operation he did very well, and was soon in less pain than he had experienced for some time.

To be continued.

MEDICAL WARDS.

The following cases were admitted from Feb. 12 to Feb. 18, 1874.

MIRIAM (Clinical).

20—Hydatid of Liver
25—Diaphregmatic Hernia
27—Heart Disease, Mitral
30—Pelvic Obstruction

JOHN (Clinical)

1—Cerebral Disease
5—Lardaceous Disease
7—Pleurisy with Effusion
14—Sclerosis of Spinal Cord

PHILIP

4—Pleurisy
6—Pleurisy and Bronchitis
25—Diabetes Mellitus
28—Dyspepsia
42—Bronchitis and Emphysema
45—Diabetes Insipidus
47—Pleuro-pneumonia
50—Herpes

ASTLEY COOPER

9—Acute Rheumatism
11—Mitral Disease
13—Acute Bronchitis

STEPHEN.

3—Rheumatism
7—Right Hemiplegia with Aphasia
1—Eczema of Face
17—Rheumatism
18—Syphilis
22—Bright's Disease
29—Eczema
28—Bronchitis
44—Phthisis

MARY.

2—Headache
4—Phthisis and Pleurisy
17—Vomiting

ADDISON.

10—Alcoholism
12—Morbus Cordis, Mitral Disease
13—Hæmatemesis
22—Infantile Paralysis
25—Typhoid (?)
30—Tapeworm
41 (Cot) Congenital Syphilis

SURGICAL WARDS.

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The following cases were admitted from Feb. 12 to Feb. 18, 1874.

ACCIDENT.

7—Fracture of Base of Skull—Death
21—Fracture of Fibula

CORNELIUS.

5—Contusions of Abdomen—Ruptured Intestine—Death
11—Injury to Wrist, excessive pain
16—Lacerated Wound of Leg and Knee-joint—Amputation of Thigh
17—Fracture of Third Metatarsal Bone
20—Fracture of Os Calcis

LYDIA

No Admissions.

MARTHA

1—Ulcer of Leg
4—Ulcer of Rectum
5—Necrosis of Metatarso-phalangeal Joint of Great Toe
6—Concussion—Fracture (?)
72-Necrosis of Ilium (?)
9—Abscess in Thigh—Periostitis
10—Disease of Knee
13½-Œdema of Glottis from Scald—Tracheotomy
14—Abscess in neighbourhood of Anus
19—Inflammation of Parts around Knee-joint

JOB.

14—Ulcer of Leg

LUKE

0—Stricture

LAZARUS.

8—Fistula
13—Necrosis of Humerus
14—Rupture of Urethra
16—Hydrocele

CHARITY

14—Rupture of Perinæum
15—Suppurating Corn of Toe

NAAMAN.

1—Carcinomatous Tumour of Upper Jaw, Recurrent
2—Dislocation of Shoulder (5 weeks)—Reduction
11—Stricture
12—Stricture
16—Enlarged Bursa Ischii

DORCAS

6—Aneurism of Anterior Tibial
7—Injury to Ankle
8—Carcinoma of Breast
9—Carcinoma of Breast
12—Necrosis
16—Cleft Palate
18—Injury to Spine
20—Bursa Patella
22—Scalp Wound
24—Scald of Glottis—Tracheotomy
26—Severe Scald—Death

BARNABAS (Ophthalmic)

24—Corneo Iritis
25—Corneo Iritis

RUTH (Ophthalmic)

41—Closed Pupils (both Eyes)
35—Hypermetropia

APOTHECARIES' HALL.

Medicine.

1. Give the symptoms, physical signs, diagnosis and treatment of pleurisy.

2. Enumerate the cutaneous diseases which owe their origin to parasites, and give the treatment of each.

3. What are the peculiarities of the continued fevers?

4. Describe the uric acid, oxalic and phosphatic diatheses. and the treatment of each.

5. What have been the various theories of pulmonary tubercle.

6. What are the therapeutical effects and uses of Digitalis, Tartar Emetic, Aconite, and Ergot.

Midwifery and Diseases of Children.

1. What is meant by tedious labour, and give your treatment.

2. What are accidental and unavoidable hæmorrhage? Give the treatment.

3. What are the morbid conditions of the os and cervix uteri?

4. Give symptoms, pathology, and treatment of acute Hydrocephalus.

Forensic Medicine and Toxicology.

1. Give a short sketch of the animal poisons.

2. Give the treatment of poisoning by oxalic acid, prussic acid, belladonna and arsenic.

3. How would you get the following poisons from the stomach :— tartar emetic, corrosive sublimate, opium, and lead,

Clinical Case.

Double aortic disease.

GUY'S LYING-IN CHARITY.

STATISTICAL REPORT FOR AUGUST, 1873.

Number of single births	160	
Number of double births	4	
Number of women confined		— 164
Of the the children born there were—		
Living males	87	
Living females	76	
Stillborn males	3	
Stillborn females	2	
Number of children born		— 168
Of the presentations there were—		
Vertex	164	
Foot	2	
Head, arm, and foot	1	
Knee	1	
		— 168
Operations—		
Turning	1	
		— 1
Deaths among the mothers		... 0
Of the women delivered there were in their		
1st Confinement	19	
2nd ,, ...	28	
3rd ,, ...	25	
4th ,, ...	20	
5th ,, ...	17	
6th ,, ...	8	
7th ,, ...	7	
8th ,, ...	9	
9th ,, ...	12	
10th ,, ...	3	
11th ,, ...	6	
12th ,, ...	5	
13th ,, ...	2	
14th ,, ...	2	
16th ,, ...	1	
		— 164
Of the cases—		
Mr. Maltby attended	25	
Mr. Clowes ,, ...	23	
Mr. Snook ,, ...	31	
Mr. Pritchard ,, ...	32	
Mr. James ,, ...	27	
Mr. Barlow ,, ...	26	
		— 164

G. F. K. SMITH, Senior Resident Obstetric.
W. H. A. JACOBSON, Junior ditto.

FOOTBALL CLUB.

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Last Saturday two fifteens from Guy's contended with two fifteens from University College, one match being played on the ground of the former at Blackheath, and the other on that of the latter at Victoria Park.

I. GUY'S v. I. UNIVERSITY COLLEGE.

The Blackheath match, in which the first fifteens were engaged, excited great interest, it was the return to one played before Christmas, which ended in a draw in favor of Guy's. The weather was bright and dry, but a strong and gusty wind which blew straight across the ground rendered kicking uncertain. University having won the toss, the ball was kicked off by Gray at 3.45, the delay being caused, we believe, by the late arrival of several University men. Both teams played their full strength, and the match proved very fast and good, Guy's and University being by far the strongest hospitals this year. For the first 10 minutes the ball was kept near the centre of the ground, but gradually by some good forward play, aided by some long drop kicks from Power, the ball was worked down near to the University goal, and Maclean very nearly obtained a run in; this failing, however, the ball was forced over the touch line and a touch-down scored. The ball having been once more started, it was soon again carried down into close quarters with the 'Varsity goal; the play of the Guy's forwards was very good at this time, Pinching especially being conspicuous, several times taking the ball through the centre of the scrimmages. Breach also was in capital form and before half time he succeeded in making a fine run in. The place kick was entrusted to Gray, who is usually a very safe goal kicker, but unfortunately, owing to the very high wind it was next to impossible to kick a goal, and the try (a very difficult one) was unsuccessful. The ball was not touched down by University, but was run in with by Alford, their captain, who throughout the match played with great brilliancy, a few minutes after this half time was called, the ball being still near their goal. After half time nothing whatever was scored by either side; the Guy's goal, however, was never in danger throughout, while the ball was towards the end forced very near to the University goal, the call of no side preventing anything being obtained. The game was thus left down in favour of Guy's by a try and a touchdown to nothing. For University Alford and Hunt played well; while for Guy's Pinching, Power, Breach and Gray were most noticeable, the drops of Power being most startling. The following formed the Guy's team :—(forwards), Pinching (captain), Robson, Gilbert, Rendall, H. Duke, Welchman, Breach, Wells, Gibb and Wallis; (half backs), Maclean and Finch; (three-quarter back), Gray; (backs), Power and Pearson.

II. GUY'S v. II. UNIVERSITY COLLEGE.

This match came off at Victoria Park last Saturday, and after an evenly contested game resulted in a draw in favour of Guy's. For the latter Brown made some very good runs, while Bain and Reader among the forwards played well up. For University—Clarke, Norson and Tate were especially noticeable. Team, Guy's :—Elliott and Jackson, (backs); Brown and Boughton, (half backs); Mutch,

(captain); Carey, Collins, Duke, Reader, Bain, James, Levien, Peskett, Roberts and Mainwaring. University:—Strong and Tate, (backs); Davies, (captain); Clarke and Harding, (half backs); Norson, Sankey, Gibes, Silcock, Routh, Rinwell, Hicks, Jones, Lloyd and Nicholson.

A photograph of the first twenty, in uniform, has been taken by the London Stereoscopic Company. Copies, price 3s. each, may be obtained on application to P. F. Gilbert. Hon. Sec.

The next meeting of the Students' Bible Class will be held at Hibernia Chambers, London Bridge, on Tuesday, 24th inst., at 6.30 p.m. Subject, John xv. 1—16.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country.

VOLUME I, of "Guy's Hospital Gazette," from October 1, 1872, to April 26, 1873; all the numbers are very clean; price 10s.—Address, at the Publisher's, 104, Borough High Street.

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HINTS ON OPHTHALMIC OUT-PATIENT PRACTICE, By CHARLES HIGGENS, F.R.C.S., Assistant Ophthalmic Surgeon, Guy's Hospital.

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Session GUY'S HOSPITAL. 1873 and 1874.

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Guy's Hospital Gazette.

VOL. III.—NO. 22. SATURDAY, FEBRUARY 28, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE

GUY'S HOSPITAL IN THE OLDEN TIME.

When Guy's Hospital was first opened, in the year 1725, Mr. Cooper and Mr. Croft were appointed surgeons, and Dr. Jurin and Dr. Oldfied physicians. It is remarkable that the name of Cooper should have inaugurated the opening of the institution—a name which was afterwards destined to shed lustre on our walls. There is no reason, however, to suppose that this first surgeon was related to the Coopers of modern times—Sir Astley, Bransby his nephew, and Sir Astley's uncle. Of this first appointed staff Dr. Jurin was the most celebrated, in fact he was one of the most distinguished physicians that Guy's has ever had. He was a man of immense learning, and wrote treatises on philosophical and mathematical subjects. As reflecting some light from the great Newton he is of interest to us, for he was secretary of the Royal Society when Sir Isaac was president.

The second surgeon to the Hospital was Sharpe, one of the most celebrated operators of the day. He wrote a work on Surgery, which is to be found in our Library,

Mr. Cooper, the uncle of Sir Astley, was a good surgeon, but there is a tradition that his skill was surpassed by his tenderness of heart, as the following story testifies:—He was about to amputate a man's leg in the hospital theatre, when the poor fellow, terrified at the display of instruments and apparatus, suddenly jumped off the table and hobbled away. The students burst out laughing, and the surgeon, much pleased at being excused from the performance of a painful duty, exclaimed, "By God, I'm glad he's gone!"

Amongst the distinguished lecturers at Guy's was Allen, the founder of the establishment in Plough Court. He was both professor here and at the Royal Institution. In his life there are various allusious to the debates at the Physical Society of Guy's, whose meetings were held in the same room where its members still perpetuate the glories of the past. Thus—"Jan. 2, 1802.—Joseph Fox invited me to meet Dr. Jenner, Astley Cooper, &c., at his house, and go from thence to the Physical Society at Guy's, a paper on cow-pox being then before the society." Allen was a strong opponent of the slave trade, and declared he would never touch sugar until slavery was abolished, and it is said he stedfastly adhered to his resolution. There is a story told of the elder Babington, inviting Allen to tea and offering him diabetic sugar, but history does not declare whether he partook of it.

LECTURES ON MEDICINE.

BY DR. WILKS.

—o—

(*Continued from page* 163.)

DISEASES OF THE RESPIRATORY ORGANS.

PHYSICAL EXAMINATION OF THE CHEST.

Before taking the diseases of the chest individually, I shall occupy your time for two or three lectures on the subject of physical examination. This method not only includes auscultation and percussion, but the shape of the chest and its movements. Indeed, there is no fact in connection with its formation and action which is not important, and therefore writers have done well to discuss them in all their particulars. As, however, I do not wish to burden your memories with any but the most important facts, I shall say nothing but what you may easily remember.

I will first write you out the following list of the leading

physical signs on which we rely: these include—Inspection Palpation, Mensuration, Percussion, Auscultation.

1. INSPECTION
   - Form of chest: Small, pigeon, narrow, flat; Large, barrel shape; Inequality of sides
   - Mode of Expansion: Inequality of sides or parts; costal, diaphragmatic
   - Mode of Breathing: Quick, dyspnœa, cardiac; apnœa, rhythm
2. PALPATION
   - Amount of expansion
   - Fremitus, voice, bronchi, pleura, heart
3. MENSURATION
   - Mechanical measurement
   - Vital capacity
4. PERCUSSION
   - Tympanitic
   - Dulness or tonelessness
   - Natural resonance
   - High pitched note
   - Amphoric resonance
   - Cracked pot sound
   - Feeling of resistance
5. AUSCULTATION
   - A. *Respiration*—
   - Natural tracheal sound
   - Natural bronchial sound
   - Natural breath murmur, deficient, increased, interrupted, altered rhythm
   - Larger bronchial tubes—râle muqueux, râle sonore, rale sibilant
   - Capillary tubes—subcrepitant rale
   - Air cells—fine crepitation
   - Tubular breathing over consolidated lung
   - Cavernous breathing over cavity
   - Gurgling
   - Amphoric
   - Pleuritic rub
   - B. *Voice*—
   - Bronchophony over consolidated lung
   - Pectoriloquy over cavity
   - Œgophony
   - C. *Cough*—
   - Amphoric resonance
   - Metallic tinkling
   - (Bruit d'airain)
   - D. *Succussion*—
   - Splashing sound

FORM OF CHEST.—You first of all expose the patient's chest, and look at its form. This may at once give you some information as to the general structure of his figure and temperament. Any alteration of the shape of the chest has usually existed from childhood, and may be inherited, but it is seldom congenital. The causes instrumental in producing the change of shape may be accidental, but many of these causes being dependent on the constitution of the parents, may be regarded as indicative of a particular temperament. Abnormal chests may be unusually *large* or *small*. The former are usually acquired at a later period of life, the latter in infancy. At birth the chest is usually well formed, and its circumference nearly circular; and it is afterwards that alterations take place in its shape. The changes depend mainly upon the state of the lung within, and also upon the condition of the bones. Anything which prevents due expansion of the lung necessarily shows its effects on the case which holds them. Any inherent weakness on the part of the infant or acquired debility from want of food might prevent a proper inflation of the lung, or if once inflated might cause a return to the fœtal state or an "atelectasis" of parts of them. A bronchitis, by causing closure of the tubes might necessitate a collapse of the lower lobes, and thus bring about a non-expansion of the chest.

You can see how, from a want of vigorous inflation, a chest might remain in a contracted condition, and become permanently a long and *narrow* chest. You can also see how, from a bronchitis and want of due inflation of the lower lobes, the sides of the chest might fall in, and thus would be produced a form of thorax hollowed out at the sides which is by no means uncommon. If this condition were still further exaggerated, the lower part of the sternum would project and a modification of the pigeon breast would be formed. The true *pigeon* breast would not be produced, I believe, unless the bones were at the same time soft, and thus the condition not only shows that during infancy there had been a deficiency in the expansive power of the lung, but the patient was the subject of *rickets*. In rickets the bones are soft, containing less earthy matter than they should, and show instead a red gelatinous material; you will thus observe that when a ricketty child is put on the ground, the tibiæ bend forwards, the femurs outwards, and the rami of the pubes are forced inwards to produce the rostrated pelvis. Before these deformities occur you may sometimes see the chest flattened by pressure against the mother during nursing, and subsequently if the soft state of the bones continues, and anything interfere with the due expansion of the lung the chest falls in on both sides and the cartilages thrust out the sternum in front like the breast of a bird. At the same time the ribs become bent almost at right angles. This ricketty chest is no part, as far as I am aware, of the tuberculous diathesis, and therefore you must not say when examining the narrow pigeon breast of an adult that he is prone to consumption. It may be that a narrow chest shows an inherited weakness of constitution as well as that chest which is flattened at the sides, but neither of these I should regard as the form of chest mostly met with in consumptive persons. Remember, in the first place, that subjects of tuberculous temperaments are well grown and well formed people, having the limbs straight and the head and chest large. If there be any peculiarity about the phthisical or tuberculous chest it is that it is *flattened* in front; that is, broad from side to side, and narrow from before to behind; thus contrasting with the barrel-shaped chest of bronchitis. Not only is it flattened but the sternum, instead of having any tendency to project falls in slightly, and thus is seen to be depressed below the ribs. Whether this is a formation inherited from birth, or acquired during infancy I cannot say, but I strongly suspect the latter. I will, therefore, ask you to remember this form, and also the narrow chest, and the modified pigeon breast having their origin in the causes named, in all of which a phthisical condition may be subsequently developed; then, also, the ricketty or pigeon breast due for the most part to the state of the bones.

A *large* chest, or one larger than natural, is acquired at a much later period of life, and is due to long-standing bronchitis or emphysema. This chest is really larger than the natural chest during the most forced inspiration; it is also altered in shape, being rounded or barrel-shaped, the diameter from before to behind being sometimes as long as that from side to side; the back is convex, and the sternum is curved, so that the patient looks as if he were humpbacked, the upper part is rounded and large, whilst the lower is more contracted. If you watch the breathing you will see how it has come about; owing to the bronchitis and emphysema, and consequent difficulty in expelling the air, the

diaphragm has pushed up the lungs, and the chest continually heaving, its upper part has become permanently expanded. It is a form of chest worthy of your notice and not to be overlooked, for it contains in its appearance the history of the patient.

Inequality of the two sides. Now, having examined the chest as a whole, and observed whether it be malformed, look and see whether the two sides are symmetrical; one side may be larger than the other, which may indicate a pleuritic effusion, or a growth, or hydatid in the liver, or one side may be contracted or smaller, which is generally an old pleurisy, either occupying the whole side or a part; if the upper part be contracted it is very often associated with disease of the lungs and indicates phthisis.

PHYSICAL SOCIETY.

—o—

The ninth meeting of this session took place last Saturday, Mr. H. J. Pye-Smith in the chair.

After the minutes of the previous meeting had been read, the secretary, Dr. Taylor, read a communication which had been received from the relatives of the late Dr. Phillips, in acknowledgement of the resolution passed by the society at the last meeting. The chairman then called upon Mr. Lamb to read his paper on "Temperature in Health and Disease, and the effects of medicinal agents on it." In introducing the subject he referred to the history of the thermometer in Medicine since it was first used by Sanctorius in the seventeenth century to the present time. He next spoke of the advantages of temperature as accurately ascertained by the thermometer over the rough estimate made by the hand, in that the former gives objective symptoms and physical signs, independent alike of the sensations of the patient or observer, which are fixed and definite. He then passed on to consider the various causes producing alterations of temperature, viz., defect of regulating power of the nervous system; alteration of the balance of many functions; effects of external influences, circumstances, and constitution of the person; also of toxic agents; and pointed out how elevated temperature in disease may be due to actions not occurring in health; as increased combustion of carbon, the combustion heat of which is four times that of hydrogen: or zymotic processes which produce heat, after the manner of ordinary fermentation. Having shown the value of temperature generally, especially as a means of diagnosis among the insane and others, in whom considerable organic lesions may occur without any of the usual symptoms, he took up its use in spinal disease, and remarked that a knowledge of the temperature in enterica was invaluable, as it gives the earliest indications of complications, irregularities, relapse, warnings of the tendency to death; shows the transition to, and is the only sign by which we can certify the patient's convalescence. Passing on from the importance of the temperature in ague, relapsing fever, rheumatism, he discussed the effects of the various medicinal agents. 1st, of cold, stating that it was the greatest antipyretic remedy we possess; he showed that it had a twofold action on the body—first, a physiological effect, which is to abstract heat from the body and cool it; the second is a conservative physiological one, occurs soon after the first, and is opposed to it. The cold contracting the cutaneous vessels, less blood flows through them, consequently its cooling, so that of the body is diminished. And remarked that it is on the resultant of these two actions that the efficiency of the both depends, for if the first effect is in excess of the second good is done, and this in proportion as the temperature is permanently reduced nearer normal; whereas, if the second is in excess the ultimate effect of the bath is to elevate the temperature, and showed from Leibermeister's and Kurnig's experiments that this elevation of the temporature is due not only to accumulation of heat, but also to increased production, which is greater in proportion to the coldness of the bath. He brought forward cases illustrating their action, and deduced from them that the bath should be warm at first and gradually cooled, but not to a great degree, for in treating persons with eryperpyrexia, who are suffering from extreme nervous debility, the result of prolonged illness. Thus, with one patient a bath began at 87 deg., and cooled 76 deg., was sufficient to lower the temperature through 12 deg, from 107.3 to 95.4 in fifty-one minutes, and insisted on the necessity of renewing the bath each time the temperature reached its former height, and of taking frequent observations of temperature while the patient is in the bath; and not permitting it to be lowered below 102 deg. as the minimum temperature is not reached until some time after the bath, and so if reduced too low fatal collapse may result; in the cases mentioned above, the temperature fell through 4 deg. after removal from the bath. But in cases of simple functional disturbance, when there is no constitutional debility or organic mischief, as in sunstroke, he urged that greater cold might be employed with advantage, as the various organs are capable of resuming their normal functions after the temperature is reduced, as would ward off the tendency to collapse; thus, in two persons with sunstroke, the temperature was 109 deg. Fahr., and by rubbing ice over their bodies favourable results were obtained. Next, turning to the effects of warmth, he pointed out that moderate degrees of heat may be employed in lowering the temperature; for, whilst high degrees of heat, or what is equivalent, a moderate degree applied for a long time, hinders cooling and elevates the temperature of the body; lower degrees causes dilatation of the blood vessels, and as long as the surrounding atmosphere is lower than that of the body the cooling of the blood and so of the body is promoted; also, warmth increases the secretions, and so directly removes heat, a great part of which is rendered latent by the evaporation of water. Again, that exposure to a temperature higher than that of the body diminishes the production of heat, and this in proportion to the height of the temperature. In conclusion, he gave the effects of digitalis, aconite, alcohol and other drugs in reducing high temperatures, and brought forward cases in proof of this.

Mr. Shadwell who opened the debate apologised for the absence of Mr. Snook, the reader of the last paper, who would have been better able, he said, to do justice to the paper which had just been read. Mr. Lamb had kept so closely to facts that it was difficult to criticize what he had stated. He thought the cold water remedy rather severe and would prefer the treatment by aconite.

Mr. Hicks praised Mr. Lamb for his subject, which was one on which all could speak. Any one could put a thermometer in an axilla and take a temperature, but it was no such easy thing to draw deductions from that temperature. He thought variations in temperature were frequently due to some slight cause, such as vomiting or constipation, he had taken a great many temperatures since he had been at the hospital but had not learnt much from them; after delivery the temperature would frequently rise quickly to 105 deg., but after a dose of castor oil it would

soon fall; he mentioned a case where the temperature of a young woman always rose one or two deg. after the visit of a certain young man, and thought the reason was obvious; in another case a patient with hysteria was thought to have caught erysipelas from another patient in the next bed because her temperature rose to 103.5, but the next day it fell to normal; he thought the mind had more to do with temperature than was thought. Simple hyperæmia would cause a rise, as evidenced by a case where one breast became hotter than the other because the milk had appeared in it earlier. After ligature of the subclavian he had known the arm to rise in temperature although it afterwards fell. He thought we could not tell what particular disease was approaching by the temperature, we must judge of this by other circumstances.

Mr. Fry thought that the frequent taking of temperatures was a great aid to diagnosis, especially in ague; he mentioned two cases which had been diagnosed in this way, in one, which was in Clinical Ward, just before Christmas, the temperature had been found to be normal at 8 a.m., 104.5 deg. at 2 p.m., and again normal at 6 p.m. He had known aconite given in a case of pneumonia and a considerable reduction of temperature effected, it had also been used in cases of high temperature after operations with great benefit; quinine in doses of 20 grs. had been known also to avert an attack of pyæmia. He thought the morning temperature was usually higher than the evening, whereas Mr. Lamb had given 6 p.m. as the highest.

Mr. Ashby thought that some of Mr. Hicks's objections were principally applicable to cases in which only one thermometric observation had been made. In puerperal affections temperatures of 103 or 104 deg. were not at all uncommon, but they soon fell; in one case a woman had one day a temperature of 105 deg. and on the next day was found washing the steps of her house; he thought forty-eight hours' observation at least to be necessary. With reference to the use of drugs suitable ones should be selected, it was not merely sufficient to give something that would reduce the temperature; aconite might be useful in pneumonia, but hardly after operations where the peritoneum had been involved. He thought that two or three minim doses of tincture of aconite were quite sufficient, five minims would depress the system more than necessary.

Mr. Paul mentioned bleeding aa a means of reducing the temperature; in one case he had seen in Clinical Ward, the temperatnre of a child had been reduced by its means from 109.1 to 104 deg. although death soon afterwards occurred; in another case which Mr. Duran had published in the *Guy's Hospital Gazette*, bleeding had reduced the temperature considerably.

Mr. Hetley very much agreed with Mr. Lamb's remark, that it was not necessary to reduce the temperature by artificial means, unless it had risen so high as to be incompatible with life; 109 deg. would kill of itself, and in that case means ought to be used; but in pneumonia with a temperature of 105 deg., no permanent good would be effected. He did not agree with Mr. Lamb that after hæmorrhage in typhoid fever the morning remission of temperature was lost, he thought the immediate effect of the hæmorrhage was somewhat favourable.

Mr. Eastes also thought that a great fall of temperature in typhoid was rather characteristic of hæmorrhage. The charts taken at Guy's were not very satisfactory, for whereas the evening temperatures were always taken between 9 and 10 p.m., the morning temperatures were taken at any time up to mid-day; the highest temperatures he had taken were between 4 and 8 p.m., and therefore the Guy's charts never showed the highest temperatures. He disagreed with the previous speaker that cold baths might do more harm than aconite, he thought that the temperature might be reduced 5 deg. by the bath with less risk than effecting the same reduction by means of aconite. He mentioned a case where constipation had caused a rise of temperature after ovariotomy, and also an interesting case of left hemiplegia where although the temperature was equal on both sides, the left side of the body was perspiring freely.

Mr. Tyson thought the principal point in Mr. Lamb's paper was the way in which he had suggested cold baths should be employed. With regard to the alleged severity of the bath treatment, the disease was severe and therefore demanded a severe remedy.

Mr. A. H. Jones thought much of the severity of the cold bath treatment was due to moving the patient; he thought aconite treatment quite as severe.

Mr. Richards suggested that drinking large quantities of cold water might reduce the temperature.

Mr. Bevan agreed with Mr. Ashby that aconite might be dangerous in some cases. He thought we might diagnose between pyæmia and rheumatism by the thermometer, and also between tubercle and pyæmia, illustrating the latter by a case in Clinical Ward. He did not attribute much value to the use of quinine or ergot.

Mr. Lamb having replied, a vote of thanks was moved by Mr. Eastes, seconded by Mr. Hicks, and carried unanimously.

The chairman announced that the next paper would be read by Mr. A. H. Jones on "Jaundice."

The meeting then adjourned.

MEDICAL WARDS.

The following cases were admitted from Feb. 19 to Feb. 25, 1874.

MIRIAM (Clinical).

21—Mitral Disease
22—Pneumonia
23—Peliosis Rheumatica
28—Sclerosis

JOHN (Clinical)

3—Chorea
4—Chronic Alcoholism

PHILIP

41—Bronchitis
42—Old Pleuro-pneumonia
43—Syphilitic Periostitis
48—Rheumatism

STEPHEN.

5—Phthisis
13—Phthisis
14—Bronchitis
15—Broncho-pneumonia
19—Paraplegia
44—Bronchitis (dead)
49—Bronchitis and Asthma—Mitral Disease

MARY.

5—Diarrhœa
14—Bright's Disease

ADDISON.

1—Gastric Ulcer
3—Bronchitis
23—Chlorosis
26—Hysteria
36—Scurvy

ASTLEY COOPER

12—Chorea

SURGICAL WARDS

—o—

The following cases were admitted from Feb. 19 to Feb. 25, 1874.

ACCIDENT.

7—Wound of Superficial Palmar Arch
8—Injury to Abdomen—Hæmorrhage from Liver?
10—Compound Fracture of Skull—Depression—Elevation of Bone—Death
13—Sprain of Foot
15—Fracture of Tibia
25—Stab in Leg and Arm

CORNELIUS.

1—Injury to Knee
21—Fracture of Thigh

LYDIA

No Admissions.

MARTHA

3—Carcinoma Mammæ
14—Carcinoma Mammæ
20—Contusions of Head and Arm
20½-Scalp Wound—Contusion of Head

NAAMAN.

8—Disease of Elbow-joint
17—Osteo Sarcoma of Leg

LAZARUS.

8—Dislocation of Shoulder
10—Stricture
12—Crushed Fingers—Amputation of Three
18—Varicose Veins of Leg

JOB.

7—Injury to Ankle—Old Fracture of Astragalus?
21—Stricture

LUKE

3—Talipes Equinus
10—Stricture
11—Stricture
14—Hernia Testis—Malignant
18—Abscess-Periosteal-Lower third of Thigh
21—Disease of Hip

CHARITY

2—Breast Tumour of Cystic Carcinoma?
25—Periostitis of Tibia
26—Talipes Equino-varus

DORCAS

2—Supernumerary little Finger—Amputation

RUTH (Ophthalmic)

29—Strabismus
30—Epiphora
34—Granular Lids
39—Strabismus
46—Strabismus

BARNABAS (Ophthalmic)

5—Ectropion (both Eyes)
12—Cranulations—Pannus
18—Cataract
19—Cataract
21—Glaucoma
25—Closed Pupils

THE WHOLE TRUTH ON THE PART OF THE PLAINTIFF.

Have you ever had a Subpœna? No? Well, when you become House-surgeon, which I wish you may in time, you will no doubt have several. The first that comes will be quite a little sensation, you will perhaps read it; by the way you may never have seen one, so I may as well tell you what it is like: it is a longish narrow slip of dirtyish bluish paper, one side printed close and the other indorsed with stiff-looking writing, to say who is the tormentor that persecutes you with it. The printed side has a serious official look, something like a death or marriage, or birth certificate. There is nothing inviting in its style: it does not seem as if you were meant to read it. But as it is the first you ever saw you may wish to know what it says, and then you will perhaps require to go over it more than once to discover its meaning. That is because there is so much effort to make it extra plain. Thus, you are told you must "Be and appear in your proper person at Westminster Hall." This order reminds you of a more worthy rendering of the same idea in the caution on the nigger placard, "No ge'lman 'mitted unless he comes hisself." So far there is no serious difficulty, but lower down it says you are when there to 'Tell the truth on the part of the plaintiff."

Now, the first time I got a subpœna, this direction sternly stamped on the official slip, and followed by grave threats and a challenge from Sir William Cockburn, in the name of the Queen, sorely exercised my spirits. I gave the matter much thought, and yet never could get over the three things urged on me. First, there was the *truth*. Then, secondly, there was the *part of the plaintiff*. And, lastly, there were Sir William and the Queen, and what they would do to me, if I did not tell the truth on the part of the plaintiff. After some feverish contemplation I arrived at a determination to ask the judge about it. I resolved that when I got into the box, I would say, humbly addressing the judge, "Would your Ludship allow me so ask a question on a point of conscience?" I thought he would of course say, "Speak up, Sir," or words to that effect. Then I should rejoin, "May I ask your Lud-

ship what I am to do if the whole truth won't go on the part of the plaintiff, if some of it is, for instance, on the part of the defendant ?"

Well, the day came, and I got into the box ; but somehow I did'nt ask my carefully-prepared question. Whether it was the lot of people looking up at me. or the wigs the barristers wear to terrify witnesses, or the horrible atmosphere of the court, I could'nt get my question to my lips before I was blandly asked in a re-assuring tone if my name was "Pilocereus," and if I lived at Guy's Hospital ? And before I got over the effect the sound of my voice in a new place had on my nerves, the wig and questions of the bland barrister took possession of my whole attention, so that all general notions of truth had gone to the winds ; until somebody said, "That'll do, sir, you can step down."

When the trial was over I was glad I had'nt asked my question. I h d learnt a little by that time. I had heard oth er people give evidence, and then it seemed to me that the reason why the Court "subpœnas" you to tell the truth on the part of the plaintiff is because the Court is in a difficulty, out of which the easiest way is to make this ridiculous demand upon you. And I soon perceived that the Court does not lose sight of the natural opposition between the whole truth and the part of the plaintiff. You will find you are not trusted to your own guidance in such a delicate dilemma. You are drawn out by a machinery of double plan; one side of which is organised for the part of the plaintiff, and the other is organised for the whole truth and a little more if possible.

After you are sworn to tell the whole truth there rises one in a periwig. He is the organ of the part of the plaintiff. He proceeds to deliver your perspiring frame very gently and carefully of so much of your conscientious fulfilment of your oath as pleases him to hear, and he discourages any more. Meantime look at the wigged one beside him who is about to rise ; how his eyes glitter ; he is the accuser of your faith ; his limbs are alive with suppressed action; his hair would probably bristle, but he wears a wig to keep it down ; he might be crouched for a spring upon the ridiculous mouse your labouring importance has just been relieved of.

Wait a moment and you will find that he is the organ of the whole truth and a little more, if possible. By the time these venerable, but somewhat obsolete-looking personages have done with or for you, you will shrewdly suspect why the Court cared so little for common sense in the stern invitation of the subpœna. When they get you before them, you are "sworn" on a dingy little volume (they are careful to show who every one is, but I did not see them take evidence what the little book was) by a person who mumbles at you something inaudible. But the impatience of the Court seems to growl out what the savage bridegroom said when his tender bride hesitated over the oath to love and obey—"Leave that to me, I'll see to that."

And the Court appears to be right when you hear the plaintiff's witnesses ; his next friend, for instance, evidently only read about speaking on the part of the plaintiff, and for got the rest. So that the judge has to check his clumsy prevarications with—"Do you think, sir, if you hide your head like an ostrich that the jury won't see your great big body." To which the organ for the whole truth smilingly adds, "Yes, Mr. Brown, the jury see your great big body." Now, no doubt the disregard of common sense in the invitation, and the mutter of the slighted oath fits well such witnesses. But, when a medical man comes forward in a position which is entirely judicial, so that he cares neither for plaintiff nor defendant. It it absurd that he should be told to speak the whole truth on the part of the plaintiff.

It is an outrage on common sense that the plaintiff should have power, first to drag a busy medical man day after day to Westminster at a ridiculous guinea per day, and, second, the dangerous power of feeing him with twenty guineas a day ; while the Court furthers the natural bent of such a course by ordering him to speak "on the part of the plaintiff" and the absurdity becomes grotesque when a gentleman in a funny head-dress, suggesting that the whole thing is odd and comical, or indirect, and out of the straight, is set up on purpose to make medical truth fit the part of the plaintiff. Such machinery might easily act as a perjury-press with a little tact in using it, and the doctor subjected to it might well ask "What is Truth ?" Only there would be such an outcry in the court. Indeed the loud mention of the word would scarcely be thought acceptable to or properly well-disposed towards the legal people there. Seeing that if Truth were to prevail their occupation would be gone. No wonder, then, they want some impossible thing conveniently labelled *truth*, but demanded to be spoken *on the part of the plaintiff*.

PILOCEREUS SENILIS.

BOXING AND FENCING CLUB.

To the Editor.

Sir,—A general meeting of the club was held recently in the Anatomical Theatre, when the old committee resigned, and a new one was appointed, consisting of Messrs. W. C. James, E. Duke, T. C. Barlow, Maylard, F. H. Stephens, and Turner, to whom was entrusted the entire management of the club. Mr. Turner was unable to accept the appointment, and the committee chose Mr. A. C. Lacey to take his place. It was thonght desirable to hire rooms near the Hospital, which members could use for general club purposes, as well as for boxing and fencing, but after a good of enquiry, though suitable rooms were found, yet, on reckoning the cost of the furniture, rent, and apparatus, it was also found that not less than £75 a year would be required for such an arrangement, and the committee decided that, though this sum might possibly have been raised at the commencement of the session, it could not be in the middle; this idea was therefore given up, and boxing and fencing will take place in the open air. A box or cupboard is to be placed in some convenient part of the Hospital, in which the properties are to be kept, by kind permission of the Treasurer. The subscriptions will be received by any of the committee. Hoping that all the students will avail themselves of the privileges of the Guy's Boxing and Fencing Club by becoming members,

I am, Sir,
Yours obediently,
WALTER C. JAMES, President.

P.S.—I beg to enclose a copy of the rules.

RULES.

1.—This Club is called the "Guy's Boxing and Fencing Club."

2.—The Committee who have the entire Management of the Club are chosen every October by the Members.

3.—The Committee are not pecuniarily responsible in the event of deficiency of Funds.

4.—In the event of any Member of the Committee resigning, the remainder have power to appoint another Member in his place.

5.—A List of the names of the Members of the Club is posted near the place where the property is kept, and none but those whose names are so posted are allowed to use it.

6.—Members must replace the properties of the Club in the box or stand provided for their reception.

7.—Members must not keep the gloves, foils, singlesticks or any other portion of the Club property for more than ten minutes if another Member wishes to use them.

8.—They must not use instruments broken or out of order.

9.—Any Student of Guy's Hospital may become a Member of the Guy's Boxing and Fencing Club by paying the subscription and observing the Rules.

10.—The Committee have power to add to or alter these Rules.

FOOTBALL CLUB

—o—

I. GUY'S v. KING'S.

The return match between the above took place at Victoria Park last Saturday, and turned out a very hollow affair, for, after an hour's play, Guy's were hailed the victors by 7 goals, 3 tries, and 6 touchdowns to nothing. The tries were obtained by Rendall (2), Pinching, Gibb, Keer, Gray, Wallis, Gilbert (2), and Robson. The goals were all kicked by Gray. The following formed the Guy's team :—Forwards—Pinching (captain), Robson, Hetley, Rendall Gibb, Mutch, Wallis, Wells, Keer, Gilbert ; half-backs—Gray and Brown ; three-quarter back—Welchman; backs—Breach and Wallis.

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(Signed)

J. C. STEELE,
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Guy's Hospital Gazette.

VOL. III.—No. 23. SATURDAY, MARCH 7, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE

LECTURES ON MEDICINE.

BY DR. WILKS.

—o—

(*Continued from page* 173.)

DISEASES OF THE RESPIRATORY ORGANS.

PHYSICAL EXAMINATION OF THE CHEST.

We next come to the *mode of expansion* of the chest, by observing whether the two sides dilate equally. This is very important to notice, since the impaired mobility of one side necessarily points to recent or old disease on that side; and it is also important to take note of the unequal expansion of parts of the same side, as, for example, a deficient movement of the upper or lower part, and which generally implies the existence of a former pleurisy. You must also observe whether the ribs and diaphragm are doing their work in the right proportion, for there are causes, especially those existing in the nerve centres ruling over the respiratory process, which may either paralyse the movement of the chest or the diaphragm respectively, and thus we say the breathing is costal or diaphragmatic. Also in cases of emphysema and capillary bronchitis, where the lower lobes of the lungs tend to become airless; a want of due expansion of the chest is very noticeable at its lower part, while the upper part is heaving at every breath.

Mode of Breathing and Rhythm.—You will first observe if breathing is *quickened*. This may be simply nervous in persons who are well. If associated with acute illness it should make you at once suspect some inflammation in the chest. If the increased rapidity has been constant for some time you may suspect a chronic disease as phthisis. *Dyspnœa* is difficulty of breathing, and the term should be used in no other sense. It means the cases where the air enters the lungs with difficulty, owing to impediment in the air passages, and is therefore applicable to cases of laryngitis and bronchitis. A third form of altered breathing is seen in the case of breathlessness, shortness of breath, or *cardiac apnœa*. This is not dyspnœa; there is no difficulty in getting the air into the chest, but the breathless condition is due to the irregular manner in which the blood reaches and passes through the lungs. You must remember that there is an intimate relation between the action of the heart and the respiratory process. The heart beats four or five times to every respiration, and as much blood as is sent in on one side is received on the other. It is very evident, therefore, that to preserve the equilibrium any increased activity of one organ should be reciprocated by the other, and this occurs in active exercise, or in febrile conditions, but in any disease of the lungs inducing impediment to the flow of blood the heart suffers; it becomes overloaded, the venous system gorged, and serum at last exudes in the form of dropsy. In like manner if the heart be acting irregularly, or be weak, and therefore cannot propel the normal amount of blood into the lungs in a regular manner, or cannot receive it in due quantity on the other side to propel it onwards, the respiratory process is interfered with, the due relation between the circulating blood and air is deranged, and the patient feels distressed or breathless. Of course the lung may be gorged at the later periods of heart disease, and a real difficulty of breathing ensue, but at earlier periods the condition is one of breathlessness or apnœa. The proportion between the respiratory act and the beat of the heart is as 1 to 4½, since the number of expirations in a minute is 16, and beats of the heart 72.

The *Rhythm* also may be altered. It may surprise you

when I say that very different opinions have been held as to the exact mode and time in which expansion of the chest takes place during breathing, but it is so, and the fact is owing to the difficulty we experience in attempting to measure accurately the movements of the chest, since directly an attempt is made to do so, the subject of the experiment having his attention fixed on himself, the natural process is thrown out of gear. The graphic method has lately been used, but this is also open to the objection named. You may remember this fact as near the truth—that if the time of one respiratory act be divided into ten parts, five would be consumed in inspiration, four in expiration, and one in rest. I am speaking of the movements only; if you regard the breath sounds heard by the ear, you will find that there is but one continuous or single respiratory murmur. In ordinary quiet breathing this is heard only during inspiration, no sound being heard whatever during expiration. In forced breathing some amount of murmur may be noticed at commencement of expiration, but if so it is quite continuous and not to be dissevered from the sound heard during inspiration. If, then, sounds are heard during expiration they are abnormal and denote disease. They are usually produced in the bronchial tubes, and therefore are not normal sounds occurring at an unusual period, but they are really new and morbid sounds. Expiratory sounds are always abnormal, and therefore especially to be noticed.

Palpation.—We now come to the next mode of examining the chest, and that is by laying the hand upon it, or by palpation. We have two objects in view by this procedure. First, to ascertain the *amount* of *movement* in the chest, and, second, the absence or presence of *fremitus*. As regards the first, the hand will often distinguish what the eye cannot; of course in well marked cases of disease, such as pleurisy, and especially with effusion, the non-expansile power of the chest is readily discernible, but occasionally there are mild cases of pneumonia or broncho-pneumonia, especially in old people, where the ear can detect nothing but the hand can readily appreciate the difference of expansion on the two sides. I have ascertained the existence of pleurisy in a patient lying insensible by this means.

Then, again, we lay the hand on the chest for another important reason, and this is to ascertain the modification of the *vocal fremitus*. This is a most important physical sign, but constantly overlooked by students. In health, when we speak, the voice vibrates through the chest, and this thrill is felt when the hand is placed upon it. Now, in some cases, as in hepatisation of the lungs, this vocal thrill or fremitus is very commonly intensified, whilst in effusion of fluid it is altogether absent. The hand will not only appreciate the difference in vocal thrill, but it will often detect a pleuritic fremitus in acute pleurisy or a rhonchial fremitus in bronchitis or a thrill in cardiac disease, more especially, of the mitral valve.

Mensuration.—Under this head we include the actual measurement of the *size* of the chest by means of tapes and the measurement of its *movements*. We include, thirdly, a measurement of the air which can be breathed into the lungs, and which is also called the *vital capacity*. As regards the first, I will refer you to your books, where you will see various kinds of apparatus used for the purposes of measurement; some of these taking the form of the chest, and others which are graduated, enabling you to compare the size of the two sides. There are also instruments which, by being placed on the chest, move the hand of a dial, and thus enable you to measure the amount of movement.

The *vital capacity*, or amount of air breathed, is taken by means of a spirometer, and I will here remind you of what you have already learned on this subject, because the facts are applicable to cases of disease. You know that when you breathe, the lung undergoes only a moderate amount of expansion and contraction; when you have expired to the utmost the chest is still full of air-containing lung; just as a river still contains water when the tide has ebbed. This air, which corresponds to the difference in amount between that in the inspiratory lung and that in the expiratory lung, is called the *tidal* air. The air which remains in the lung after the most forced expiration is styled the *residual* air. Now, in ordinary inspiration we do not inflate the chest to the very utmost, but if we do we breathe in an additional amount of air and this in forced inspiration is called *supplementary*. Such a condition occurs when one lung is diseased or compressed and additional work is thrown upon the other, and it is for this reason therefore very important to notice. You may also remember that when in the dead body you open the chest, the lung collapses, but if it be taken out and examined, it will be found still to contain air and it floats in water, this air is called the *persistent* air. In some cases, however, as in pleuritic effusion, every particle of air may be squeezed out of the lung, it is then a fleshy mass and is said to be carnified. The amount of respirable air is the difference between that in the fully expanded lung and that in the most forced expiration—or the tidal and supplementary air together. The spirometer has been found of little use in practice, owing to the difficulty there is in persons understanding how to use it, and then again because the amount of expansion depends upon other circumstances besides the size of the chest; as, for instance, the muscular strength of the patient; thus, a person used to athletic exercises would show a higher range on the instrument than one whose chest was of equal dimension, but who was fat and had led a sedentary life.

CLINICAL LECTURE.

—o—

ON OLD AND RECENT DISLOCATIONS OF THE HIP-JOINT

BY A. E. DURHAM, F.R.C.S.

(*Continued from page* 164.)

We said we would leave the patient three months in bed after the reduction, but in reality it was more than that before he was allowed to get up, and then of course only after a suitable stiff bandage had been applied. At this time the limb was measured in the ordinary way, and appeared to be three-quarters of an inch shorter than the other. But I will call your attention to a point in measuring the limb. You know the ordinary method is to take the distance from the anterior-superior spinous process to the head of the fibula, or to the lower border of the internal malleolus with a tape measure. Now, in limbs of equal

muscular developement this is all very well, and a true result may be obtained; but, as in this case, if the muscles of one limb be wasted, while those of the other are still rounded and prominent, it is manifest that the muscular limb has the advantage, and will appear longer in proportion to the other than it really is. And this, I believe, is how the wasted limb came to appear three-quarters of an inch short. Careful measurements with a Beam compass would have shown that there was very little shortening indeed, if any at all, as was subsequently found to be the case; there is now no appreciable shortening. When he first got up he was unfortunately so weak that he fainted, and, falling down, hurt his right hip again. This undoubtedly retarded his recovery, for he was so much injured that we were obliged to keep him in bed again for some weeks. Then Mr. Simmonds, my dresser, fitted on a very well made stiff bandage, and we permitted him to get up, this time with a more successful result. The patient is here, and I will call him in that you may see the difference between his present condition and that indicated by the drawing just handed round. You see he walks well with the aid of a stick in one hand. The muscles of the right limb are still, however, very much wasted, owing to the considerable period during which they were not used, and it will probably be some time before they completely recover. This wasted condition of the muscles is perhaps best marked in the gluteal region, which you see is flattened on the right side. And you may at the same time observe that the old injury to the ankle-joint, of which I spoke in the commencement of the lecture, still gives the limb a somewhat deformed appearance; but when we consider the improvement which has already taken place in this poor man, condemned as he was by his former condition to a life-long lameness, there is very good reason to hope that he will yet be able to follow some active employment.

Now let us consider the period at which reduction may be attempted in old cases, and here let me impress upon you that you must not allow yourselves in your practice to be bound down in all cases by those hard-and-fast rules that some are only too ready to lay down, and others only too willing to rely upon for guidance. Do not permit bare statistical deductions as to the results of special methods of treatment, nor even the authority of any great name, to keep you in any one continuous groove of treatment. But get all the knowledge—all the experience, you can. Study the recorded experience of others, and then consider every case that comes before you on its own merits, and treat it on your own judgment and act accordingly as reason dictates. Suppose, for instance, we had been guided in this case by the rules laid down by some authorities, the patient would still have been the helpless cripple that he was. Sir Astley Cooper, the greatest authority on Dislocations that ever lived, whose diagrams and teachings have been more frequently copied than those of any other writer on Surgery, lays down the rule that in dislocation of the hip reduction should not be attempted later than eight weeks after the accident. Sir William Fergusson writes that he has "seen attempts made in various instances of old standing, but has not witnessed a successful effort beyond the period of three weeks." Erichsen says, "the attempt to reduce old dislocations of the hip-joint is necessarily attended with danger, and after two months have elapsed it is seldom practicable." Gross endorses Sir Astley's opinion. And lastly, I may remind you that Bryant, in his excellent text book, says "old dislocations in a general sense should be left alone," and states that he has never seen any good result later than the thirty-fifth day. However, I am happy to believe that Mr. Bryant having since seen the excellent result in the case I have brought before you, will be able in his next edition to speak more encouragingly on the subject. But though the attempt at reduction in the case before us was scarcely in accordance with the rules generally laid down, yet you must not suppose it was by any means unprecedented; far from it, many other more or less similar cases have been already published. For example, Breschet reduced a dislocation of the hip on the seventy-eighth day, Travers at the fifth month, Blackman, of Cincinnati, at six months, Dupierris after six months, and Lenis Sayre after nine months' dislocation. These, and other similar facts which I might quote, may serve to show you that you must not be absolutely bound down by any hard and-fast rules as to the period up to which reduction of a dislocation of the hip may be attempted. The only approach to a rule on this matter that I would suggest is that the time at which and up to which such an operation may be attempted or performed is where the necessity arises or becomes apparent, and when no good reason exists why the attempt should not be made. The ground upon which I proceeded in this case I have before explained to you. I was guided entirely by the man's condition, not at all because I had any particular fancy for reducing very old dislocations. I wish you to bear in mind that I have no greater desire to lay down absolute rules, than to be guided by them. I am not arguing the that boundary line fixed by Sir Astley at eight weeks should be removed by six months or any other stated period; for while in a suitable case I would attempt reduction at six months, I would not do so at six weeks in a case where the operation was contraindicated. For instance, in some cases the bone at a comparatively early date becomes firmly fixed, and the patient can get about pretty well. In others the patient is old and the adhesions are perhaps as strong as the bone, which would break if reduction were attempted. Again, if there were reason to believe that the acetabulum had entirely grown up, and the head of the femur had become absorbed, a good result could not be expected. Such cases as these must be passed over as unsuitable for interference, but they serve to afford further argument in favour of considering and treating every case on its own merits.

(To be continued.)

On Wednesday next, at 1.30 p.m., Mr. Durham will give a clinical lecture on "The Clinical Aspects of Malignant Tumours."

Trichinosis.—At the town of Forst, in Germany, twenty-two persons have been attacked with trichinosis through eating the flesh of a pig killed by an hotel keeper. The cook and the hotel keeper have both died; the body of the former was found full of living trichinæ. Several other persons were, on February 24, dangerously ill, and new cases were coming under notice.

MEDICAL WARDS.

—o—

The following cases were admitted from Feb. 26 to March 4, 1874.

JOHN (Clinical)

4—Pleuro-pneumonia
16—Bright's Disease

MIRIAM (Clinical).

24—Peritonitis

PHILIP

10—Heart Disease
24—Heart Disease
31—Acute Rheumatism

STEPHEN.

6—Acute Rheumatism
10—Alcoholism
11—Ataxia
20—Incipient Phthisis
25—Gout
30—Acute Rheumatism
44—Chronic Alcoholism
45—Partial Paraplegia

MARY.

10—Acute Rheumatism
12—Dyspepsia

ADDISON.

4—Heart Disease
24—Acute Pneumonia
26—Heart Disease (aortic and mitral)
29—Chlorosis
31—Arthritis (chronic)

ASTLEY COOPER

10—Pericarditis
17—Phthisis
20—Phthisis

SURGICAL WARDS.

—o—

The following cases were admitted from Feb. 26 to March 4, 1874.

ACCIDENT.

10—Fractured Fibula
30—Compound Fracture of Arm—Fractured Ribs, &c.—Death

CORNELIUS.

1—Severely Shaken
4—Contused Side
12—Sprained Ankle
13—Injury to Knee
19—Sprained Ankle

LYDIA

1—Abscess in Side?—Spinal Disease
8—Bruised Leg
18—Cyphosis
21—Necrosis of Tibia
22—Carcinoma of Breast (right)

MARTHA

3—Sloughing Ulcer of Leg
14—Eczema Rubrum

JOB.

2—Old Injury to Ankle-joint—Amputation through lower third of Leg
5—Thecal Abscess
25—Ankylosis of Hip

LAZARUS.

1—Congenital Malformation of Foot
9—Abscess in Neck (sebaceous)
12—Carbuncle
20—Disease of Metacarpo-phalangeal-joint

NAAMAN.

8—Disease of Elbow-joint
22—Hydrocele

LUKE

7—Cystitis
17—Abscess Behind Ear
14—Old Standing Dislocation of Shoulder

DORCAS

No Admissions.

CHARITY

5—Fractured Fibula
9—Injury to Abdomen—Pregnancy
10—Epithelioma of Labium (right)
12—Abscess in Groin
16—Compound Fracture of Left Humerus
23, Cot.—Œdema of Penis

CRICKET CLUB.

At this meeting, the first in the year, thirty-one students were present. In the absence of the captain, Mr. Williams proposed that Mr. Hetley should take the chair, this was seconded by Mr. Manser, and carried by acclamation.

The chairman remarked that since no report had been taken of the proceedings at the last meeting, he thought it would be better to get on with the business at once, he therefore called upon the secretary to read his report.

Mr. Williams introduced his report with some severe criticisms on the conduct of his predecessor, who came into office with a balance of £4 1s. 0d., in 1872, and left it in 1873 with a debt of £25. This debt he (Mr. Williams,) had reduced to £16 15s. 6d. He next reported that in his opinion a good deal of money had been wasted last year in hiring

practice ground—£18—and proposed that this year the ground should only be hired for matches, recommending the Oval as the best and most convenient. Last year the 1st Eleven played nine matches, of which they won three and lost five, one being drawn. The 2nd Eleven played two, winning one and losing one. They were to have played two more, but several men scratched their names at the last moment, a proceeding which compromised the club and placed the secretary in a most disagreable position. He pointed out how some of the matches had very probably been lost through two or three men not turning up, remarking that it was an insult to the opponents to go into the field with only eight or nine men, and he especially regretted that some men had even neglected their hospital to play for other clubs, while others of the 2nd Eleven, if once required in the first, owing to a little paltry pride would not play again except in the 1st Eleven. He announced that the following matches were in course of arrangement, For the 1st Eleven :—Crystal Palace, Surrey, Yalding. Blackheath Morden, Ravenscourt Park, City, Wanderers, Erith, Bart's, St. George's, St. Thomas's, University, and Lewisham; and probably six for 2nd Eleven. He regretted that since he would be away in April, May and June, it was necessary for him to resign the secretaryship, and hoped that they would appoint some one who would look well after the finances of the club, and in whom the men had confidence, and he was sure that they never would again deserve as they did last year, the taunt that the Guy's Hospital Cricket Club "dragged out a miserable existence" (loud applause).

The chairman begged that some one would propose a secretary.

Mr. Nash proposed Mr. Boughton. This was seconded by Mr. Wilkins, and carried by a vast majority, and Mr. Boughton was declared by the chairman to be duly elected as Honorary Secretary to the Guy's Hospital Cricket Club.

The chairman remarked that since there were several gentlemen present, he thought it would be well to discuss the question of practice ground, and decide it at once. He would also be glad to hear opinions on anything connected with the club.

After some discussion it was decided that the Lewisham ground should be given up, and that arrangements should be made for practice once a week on the Oval, which would not cost more than 10s. per week.

The chairman asked whether before the close of the meeting, any gentlemen would like to propose other matches than those selected by the secretary.

Several were proposed, but it was decided that only Charlton Park and Richmond should be added to the list.

Mr. Gray proposed, and Mr. Boughton seconded, a vote of thanks to Mr. Williams for the very able and successful manner in which he had conducted the affairs of the club during the past season.

The meeting then adjourned.

Professional Women.—Mrs. Garrett Anderson, M.D., has been proposed as a member of the Obstetric Society of London by Dr. Tilt, president of the Society, Dr. Priestley, Dr. Barnes, Dr. Playfair, Dr. Braxton Hicks, F.R.S., Dr. Oldham, Dr. G. Hewitt, and other members of the obstetric branch of the profession. This has raised the question of the right of women, although duly qualified, to be elected members of that society, and the question will be discussed at a general meeting.

THE SECOND COLLEGE.

The Spring is coming on us fast,
The length'ning days are seen,
I dine at five by daylight, now,
And save the parafin.
The days increase. Alas! alas!
I wish that, too, my knowledge
Increased as fast, that I might pass,
Next month my Second College.

It's all very well for a qualified swell,
To tell me I'm not working,
But doing what's worse—writing doggerel verse,
And thus my duties shirking.
In poetry, I must acknowledge,
One's not examined at the College.

But a happy rhyme
Will often save time,
In learning a long list of facts,
Which, till practice has tested,
And long thought digested,
On the memory are but a tax.
Thus doggerel preserves the knowledge
Required to pass the Second College.

As samples are free I enclose one with this,
From it you may judge of the rest;
It has turned up the first, and may be the worst,
But certainly isn't the best.
The rhyme is the shell, but the kernel's the knowledge,
Which perhaps may be asked for at your Second College

Aneurism of Arch of Aorta.

Patient cannot swallow food
So well, he says, as once he could.
Œdema, pain, sometimes pulsation,
Something wrong with Respiration.
Five may-be causes for dyspnœa;—
Veins, vagus, bronchus, lung, trachea.
If these are by the tumour pressed,
The bre thing will be much distressed.

Students Bible Class.—The next meeting will be held at Hibernia Chambers next Tuesday, March 10th, at 6.30 p.m. The subject will be John xvi. 1-14.

The British Pharmacopœia.—We have authority to state that a new edition of this valuable official work will be issued next week. An important 'addendum' will contain formulæ for new remedies which have been introduced into practice since the last edition was published. The main labour of its production has fallen upon Dr. Quain, F.R.S., and professor of Redwood.

The Government and the Medical Council.—The new Government, following out arrangements of their predecessors on the point of completion, have offered to the General Medical Council the premises in Oxford Street formerly occupied by the College of Chemisty. They are offered at a very moderate rent. Mr. Lowe, however, had admitted the right of the Council to premises free of rent.

CORRESPONDENCE.

—o—

[*We do not hold ourselves responsible for any opinions expressed by our Correspondents.*]

To the Editor.

Sir,—This is an era of surprises. Mr. Gladstone at home, and King Koffee on the Gold Coast, have recently effected great things in this line, but it has been reserved for the *Guy's Hospital Gazette* to convey to its readers an intimation which, painful as it must be to all who have the welfare of the Hospital at heart, must utterly eclipse the performances of the ex-Premier and his rival.

To be brief, Guy's is on the verge of bankruptcy; or, if affairs have not quiet reached this pass, a consideration of the following facts—which can be vouched for—abundantly proves that such a catastrophy cannot be far off:—

Fact No. 1—A patient was admitted on Feb. 27th, into Clinical Ward, suffering from delirium tremens.

Fact No. 2—He was seen, and prescribed for, by the Physician in charge.

Fact No. 3—Within less than twelve hours from his admission, he had to be handed over to the tender mercies of the police, whose successful treatment of alcoholism, has formed the subject of several recent coroners' inquests.

Fact No. 4—The Physician in charge protested strongly against this course.

Fact No. 5—The reason assigned for this proceeding was that, existing arrangements did not sanction the expense of a skilled attendant on, or provide proper accommodation for, such troublesome cases.

Fact No. 6—The Hospital's income is at least £40,000 per annum.

Fact No. 7—The stipend of the skilled attendant would not exceed 6s per diem.

To what is one necessarily led by a consideration of these facts?

That, in these days of improvement, it is possible for the largest hospital in London, with the largest staff, and the largest revenue, to exist without a suitable ward wherein a refractory patient can be restrained from being a nuisance to himself and others, and that the expense of special attendants for this class of cases is too great to be borne by an institution with the annual income ours possesses.

That, in that Hospital not even an occasional opportunity is given to students of watching the care of, or the effect of therapeutic agents on, a condition unfortunately only too common, unless that condition be so modified by medical or surgical complications that the most important part of its treatment—moral management—is reduced to a mininum, when so much minute and indefatigable attention is bestowed on such cases as chronic rheumatic arthritis, old standing hip-joint disease, or hopelessly intractable ulcers.

That the superintendent, who, I am certain, regrets deeply such really flagrant failure in the possible usefulness of the institution, has no choice but to act in direct opposition to the wish of the medical officers.

Who can look at the one, wretched, ill-ventilated strong room, with only three beds, as it at present exists, with its imperfect set of straps, its nurse frequently an inexperienced woman, whose pay, to judge by the rapidity with which patients sent there are removed, is begrudged, and whom it often takes hours to obtain.

Who, when the treatment of a distressing condition, which might well occupy the time and skill of the most accomplished physician, has to be delegated to workhouse authorities, because no one has thought it worth while to get out of an old plan which, however necessary it might have been before the new buildings gave sueh increased scope for the relief of suffering, can, while wards like Petersham stand empty, be scarcely necessary now, and who considers the serious consequences that may ensue from want of the due quiet and attention that a separate and easily accessible ward with a permanent staff of attendants could so easily secure.

And lastly, who, when our hospital system compels the welfare of the patient, the interests of the students, and the earnest remonstrances of the physician to be utterly set at nought, is there but must feel that it is a lamentably defective one; and who is not sure that a sufficient movement of public opinion by the Editor of the *Gazette* would be of material assistance to the authorities in obtaining the desired reform.

Yours &c.,

X.

DENTAL HOSPITAL OF LONDON.

THE opening of the new and commodious Dental Hospital in Leicester Square on the 2nd inst., was celebrated by a *conversazione* of the Managing Committee and the Odontological Society of London and friends. It differed in no way from the usual semi-social, semi-scientific gatherings of the same kind. There was a short inaugural address delivered by the president of the institution (Mr. Sercombe), which simply pointed out the objects and purposes of the hospital, and then the visitors were left to their own devices. There was plenty to interest them, for though no ladies were present some of the most eminent surgeons of the day were. The object of the hospital is solely to cultivate the science of dental surgery in its highest branches. It is recognised by the College of Surgeons, as it should be, and when a student has completed his term of study he has to pass a very strict examination before he receives his certificate of proficiency. Any person going to the hospital is attended free of all charge; but there is a box in which the well-to-do, who derive the benefit of the best dental advice, may leave, if they please, a donation to the funds of the hospital, but all money fees are prohibited. There was the usual collection of microscopes and preparations of skulls, showing all the terrible evils which teeth, and especially bad teeth, are heirs to. Nor is the mischief entirely confined to bad teeth either, for some of the skulls have beautiful teeth, though most terribly misplaced. In particular there is one which has four beautiful rows, two in the upper and two in the lower jaw, while there is part of an auxiliary third row above the other two. Whatever the Dental Hospital may do to relieve the toothache, and we are sure it will do much, still there is enough to be seen there to set the strongest teeth aching from sympathy. There are also pictures of the monstrous teeth of carnivora, which show that if they cannot be extracted they at least can be drawn altogether. The whole collection was interesting.

ON DUTY FOR MARCH.

HOUSE PHYSICIAN—
Mr. T. Eastes

ASSISTANT HOUSE PHYSICIAN—
Mr. J. Lacey Morley

JUNIOR HOUSE PHYSICIAN—
Mr. W. H. A. Jacobson

HOUSE SURGEON—
Mr. H. Hetley

JUNIOR HOUSE SURGEON—
Mr. F. T. Paul

RESIDENT OBSTETRIC—
Mr. H. Williams

JUNIOR RESIDENT OBSTETRIC—
Mr. R. Manser

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country

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All communications to be addressed to

The Editor,
"Guy's Hospital Gazette,"
Guy's Hospital, S.E.

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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

Gentlemen having cases of peculiar interest under their notice, are requested to send us the Ward and No. of Bed.

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Session GUY'S HOSPITAL. 1873 and 1874.

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Guy's Hospital Gazette.

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LECTURES ON MEDICINE.

BY DR. WILKS.

(*Continued from page* 178.)

DISEASES OF THE RESPIRATORY ORGANS.

PHYSICAL EXAMINATION OF THE CHEST.

Percussion.—This is by far the most difficult part of physical diagnosis, because there is no universal agreement as to the true conditions which produce the various sounds, and there is no exact definition given to the terms which are used; moreover many writers adopt expressions of their own selection and which cannot be accurately interpreted by the reader. For instance, the common term "resonance," how impossible it is to define it or convey in any words to you what I myself understand by it; and the same, though to a less extent, with the word "dull," but when we read in books of such expressions as "empty" and "full," the words often convey no meaning at all. I do not find fault with the attempt to give names, for it is evident that under varying conditions, different sounds must be elicited by striking the chest, but since, at the present time, we are not all agreed as to the true causes producing them, it is impossible to use expressions which are intelligible to all. I say there is no general agreement as to how the sounds are produced, some maintaining with Piorry (who has written a poem on Percussion) that every part of the body gives out its own note on percussion, whilst others, with Bennett, have been content to teach that there are three main sounds according as we percuss over a solid, a liquid, or air; these would be illustrated by striking over the liver, bladder or stomach, and therefore might be styled respectively parenchymatous, humoral and tympanitic sounds. Without systematizing too much, we are generally content to say that we elicit from the walls of the chest a given sound which varies with the condition of the ribs and their covering, but more especially according to the nature of the contents within. The sound is really produced by a vibration of the ribs which can be felt by the finger, and the note varies more especially with the contents. I have no doubt that the subject might be taken up advantageously as a simple question of acoustics, and then appropriate terms given. You will see, on a moment's thought, that the nature of the object struck must determine a difference in the note, as also whether it be solid or hollow; the sound again varying with the character of the contents.

When one considers that percussion of an object is a simple physical method of ascertaining what is within, it is remarkable that its practice has been left to modern times; we know if we knock at the door of an empty room that the hollow sound produced will tell us of its condition, just as we know by striking a barrel whether it is empty or full; in the same way the builder knows by striking a wall whether is be composed of brick or lath and plaster; and when we stop on our journey at the railway station, a man comes and knocks the wheels in order to discover a flaw. One of the most remarkable illustrations of the information to be obtained by percussion occurs in "The Mystery of Edwin Drood," the last novel which Dickens had in hand when death suddenly disarmed him of his pen. It would be most interesting to know whether he gained the idea from observing the methods used amongst us medical men, or whether, quite irrespective of us, he had merely in a fanciful and somewhat exaggerated manner described what he had actually seen performed amongst workmen. The passage is sufficiently interesting to read to you, if it be only to show how percussion is merely a matter of physics.

"Is there anything new down in the crypt, Durdles?" asks John Jasper.

"There's an old 'un under the seventh pillar on the left as you go down the broken steps of the little underground chapel. Now, lookee here. You pitch your note, don't you, Mr. Jasper?"

"Yes."

"So I sound for mine. I take my hammer and I tap. (Here he strikes the pavement.) I tap, tap, tap. Solid! I go on tapping. Solid still! Tap again. Holloa! hollow. Tap again, persevering. Solid in hollow! Tap, tap, tap, to try it better. Solid in hollow; and inside solid, hollow again! There you are! Old un' crumbled away in stone coffin, in vault."

"Astonishing!"

To simplify the matter as much as possible, I shall merely describe to you the *four* most striking different conditions in which the chest may be placed in health and disease, and which will correspond in the main to the solid liquid and gaseous already mentioned. The chest may be full of *air* or full of *liquid*, or a *solid hepatized lung*, or, fourthly, the *natural lung*. Now the sounds elicited by striking the chest under these different circumstances can be imitated by taking four boxes and filling them respectively with *air*, *water*, *wood*, or *wool*. Now, if we took an empty chest by removing the lungs and filled the one side with air and the other with water, we should have two very different sounds produced upon striking them. If we percussed the one side it would sound like a drum, and we should have no doubt that it was hollow, and we should call the sound *tympanitic*. Now, if we struck the other side we should elicit no sound whatever, no vibration would occur in the ribs, and therefore no note. This would be called *dull* on percussion, or perhaps a better term than dullness would be *tonelessness*; it would be as toneless as striking the thigh. Now, if we took another chest and placed within it some wool or spongy lung we should have necessarily an intermediate sound, we should not have the hollow sound of simple air, nor the total want of vibration, as in the case of fluid, but another note would be produced. This note produced by striking over a healthy lung, is called *natural resonance*. I cannot describe it to you in so many words, but you must familiarise your ears to the note and then you will take it as a standard; any sound above it is called hyperresonant, as you have in an emphysematous lung, which increases until you reach the tympanitic note, and anything below it implies the existence of more solid material within until perfect dulness is reached.

Now the greatest difficulty in the explanation of a note exists in the case where a solid fills the chest, as when a piece of wood should have been introduced, or when, in the living subject, the lung is hepatized. You will see that dulness corresponds to toneless, and this very often means the non-vibratile condition of the walls from the presence of solid matter within the chest, but solids do not necessarily cause an absence of tone. Thus, it is true that if I strike over the liver or a chest full of fluid I have what is called a dull sound, but if I strike over the sternum or head a different note is elicited. In this case it shows that the bone itself produces a sound, but apart from this the solids and fluids produces different notes, as would be seen by striking a barrel full of fluid, and a solid block of wood of the same size and shape. Such a mass vibrates, but the vibrations are shorter than in the hollow barrel, and not so enduring, and a *high-pitched* note is produced. This, then, is the term for a note which we often meet with in striking over a solid organ or a hepatized lung. I will take this opportunity of saying, also, that vibration and non-vibration of the chest do not necessarily indicate the presence of air or liquid beneath, for, in the case of the barrel, if a thick piece of paper were spread over its inner surface it would not vibrate on slight percussion, and it might then be thought that the vessel was full. An analagous condition occurs in the human chest when a thick layer of pleura lines its inner surface. This prevents vibration when the chest is percussed and the impression conveyed to you might be that of fluid in the chest, and thus it has happened that persons have been tapped for fluid, when they have had nothing more than a thickened pleura. There is also the converse fact that a vessel may be so full of air and tightly stretched that it will not vibrate, and thus the hollow sound does not appear; this may occur in pneumo-thorax, and is sometimes met with in extreme tympanites of the belly, where, from the great stretching of the stomach and intestines, no tympanitic sound is elicited. The experiment may be artificially made by blowing out a bladder, which is resonant or tympanitic until stretched to the utmost when the tympanitic sound is lost.

I shall leave you with these four conditions of the chest —viz., where it is full of *air*, *fluid*, a *solid*, or *spongy lung*, as the most important, and let you learn up minor conditions afterwards. I will, however, speak of two other sounds, which it is necessary to remember. I told you that when you struck over a hollow space you had a tympanitic sound, but this term is applicable only to the drummy state produced by a very large collection of air. If the hollow be circumscribed as in a cavity in the lung, we adopt the term *amphoric*, which is a sound resembling what is produced by flipping the cheeks when stretched to the utmost, or an hollow india rubber ball. An important modification of this is the *cracked-pot sound*, produced under the same circumstances as before, but with the addition of a hole in the cavity communicating with the external air. Thus, it would be produced in the india-rubber ball, with a hole in its walls, or it can be produced in the cheek by slightly separating the lips, or still better by striking the closed hands on the knee—the air rushing out between the fingers producing an almost metallic ring. In the case of a cavity, we request the patient to open his mouth, and then if there be a bronchial tube leading from the cavity direct to the trachea, and we strike sharply over the cavity, a well-marked cracked pot sound is produced. This is almost pathognomic of the existence of a vomica, for it is seldom heard under any other circumstances. on one or two occasions, in cases of hepatization of the upper lobe, I have heard a sound somewhat resembling it. In children also with elastic chests, it is easy to produce it by striking the walls whilst they are crying.

Under the head of percussion, I might refer to another physical condition, which becomes apparent during the act of striking. I mean the sense of *resistance*. When you percuss over a resonant or dull chest, your finger appreciates the vibration, or the want of it, and not only this, but it is aware whether a spongy or hard substance is beneath. In the latter case there is not the slightest giving way of the ribs, and the finger appreciates by a sense of resistance, that there is a solid beneath.

Now, it is customary to divide the chest into regions, and if you look into your books you will see various ways in which this is done. I think myself it is useless to get up accurately any scheme of the kind, as the terms are always ready at hand when we require them, as infraclavicular, suprascapular regions, and so on. You will find that the

front part of the chest is more resonant than the back part, and of the latter that the lower portions are more resonant than the upper part covered by the scapula and fleshy muscles.

By percussion on the right side you will find the lower part dull from the presence of the liver, the lungs and liver varying their position during respiration; thus, during inspiration the lung reaches to the 7th rib, and in expiration to the 5th rib, the medium of course being the 6th; we, therefore, generally say that the resonance reaches on the right side as low as the 6th rib; but there is no sharp line between the resonance and dulness owing to the lung overlapping the liver, and therefore the two sounds gradually merge into one another. On the left side the lung only reaches to the 4th rib, as it there turns off over the base of the heart.

PHYSIOLOGY OF MOTION AND SENSATION.

By Dr. PYE-SMITH.

Lecture I.

My colleague, Dr. Pavy, has been describing to you during the former part of the session, what are known as the Organic functions of man. We now enter upon the study of the Animal functions. It is important to get a clear notion, to begin with, of the difference between these groups of phenomena. The organic functions are so called because they are common to the whole of the organised creation, they belong not only to the lower animals, as well as to man, but also to vegetables—to the organic as distinct from the inorganic world. Hence they are also called *Vegetative* functions, because they are characteristic of plants as of animals. It will not have escaped your notice that all these functions, complicated as they are, to the description of which you have been listening, can be comprehended under one general term, namely *Nutrition*, that the functions of circulation, respiration, secretion, excretion, all really depend upon different methods and ways of nutrition. Nutrition or growth is necessary for plants as well as for animals; therefore it is we find this function just as well marked in trees and flowers, as in animals, including man himself. The function of *Circulation* is merely the carrying to different parts of the body of materials which have been elaborated by the process of Digestion, just as the sap which has been formed by the leaves is carried to the various parts of the plant which require nourishment. But you may find animals, just as you may find plants, with no circulation, because all parts of the body are sufficiently near to the source of nutrition. Again, *Respiration* is merely an appendage to the function of Circulation. It is to purify the blood that animals and plants breathe. So of Secretion and Excretion, whether you look to the kidney in an animal or to oil-glands in a plant, the action of both may be traced to some variation in the function of nutrition.

But we now enter on the study of totally new and different functions, functions to which we scarcely find any parallel in the vegetable kingdom. It was the dictum of Linnæus that stones grow, plants grow and live, and animals grow, live and feel. If we add that animals grow, feel, and *move*, the account would represent the popular notion of the condition of animals, vegetables, and minerals. Outside the physiological theatre, sensation and movement occupy a greater part in the sphere of human interest than all the organic functions together. Therefore, it is naturally said that movement and sensation are the characteristic function of man, or more generally of animals. But it would be vain for us to attempt to understand these functions, which, as they are the highest, are also the most complicated and most difficult, if we began by examining them in man and endeavoured to ascertain the method in which movement and sensation take place in him. We must try to find these functions reduced to their simplest expression, in the least complicated and lowest, instead of the most complicated and highest organism.

Beginning, then, with animals, which are next akin to ourselves, and passing down through the lower Vertebrata, we find not only movement performed by muscles just like our own, but this movement called into action by nervous cords and central organs, brain and spinal cord, which also are essentially the same. As it is in structure so it is in function, for, although the lowest animals seem to be destitute of what we call consciousness, yet it is not possible to draw the line where this ceases. As all our neighbours have the same muscles, nerves, and brain as ourselves, so we imagine that they have the same feelings, or conscious sensations; but if we admit this analogy, you see at once we cannot refuse to extend it to other classes. The more intelligent animals give expression to the same feelings of pain, hunger, &c., that we experience ourselves, and it is impossible to say that these feelings are absent till we have passed down to the lowest of the vertebrate series. We cannot, therefore, look upon conscious sensation and voluntary motion as functions peculiar to human, and absent from, comparative physiology. We may go lower, to animals in which there are no muscles or nervous system to be found, and even then we cannot draw the line and say,—here there is no consciousness and no will.

Here is a diagram which shows a little animal, the "changeling," *proteus* or *amœba*, which has no muscle and no nerve; but it has power of movement. Is that movement voluntary, like our own, or is it an unconscious one? If you put it in the neighbourhood of its proper food, you will see it throw out these arms, seize the food, draw it into the body and digest it. Can this be distinguished from the action that occurs when a cat kills a mouse? Who shall say that this animal is merely a machine, that eats without appetite and digests without satisfaction, while the cat takes her prey by intelligence and judgment like our own. If we imagine that the former is a purely mechanical action, then we must go further, and must say, with Descartes, that the cat, and all animals except man, are mere machines, that the race horse, in performing his course, exerts his will as little as does a steam engine. But this we cannot admit, for the same argument which denies volition to animals would lead each of us to deny it to all men but himself, and the holders of such a doctrine would each be perpetually in a minority of one.

Again, if you put a vessel of water containing amœbæ near a bright light, so that the sun falls upon half of it, you will find that after a time they crawl over to the light. This shows that they are in some manner impressed by light and heat, as well as that they exercise a choice in moving towards it. They not only have movement, but sensation, that is to say the movement is called forth in answer to a certain stimulus.

But we may go further. It is not only in the lowest animals we find this power of movement, and this power of

sensation. You know that when you touch the leaves of the sensitive plant they contract. There you have movement, and there you have, what, for the present, we must call sensation, because the leaves move in obedience to the stimulus of the finger. How can you distinguish this kind of movement from that of the amœbæ, for in neither can you find any nerves or muscle? Both animal and plant "feel" without nerves, and move without muscles. And just as we cannot refuse the terms animal movement, and animal sensation to the amaba, so we can scarcely refuse the term sensitive to the mimosa. [The case of Venus's Fly-catcher (*Dionæa Muscicapa*) was then described, and the spontaneous movements of spores referred to.]

Movement and sensation are, however, exceptional in plants, whereas they are universal in the animal kindgom: and so they may be fairly called "animal" as distinct from "vegetative" or "organic" functions. I have referred to their occurrence in plants, to which few would attribute any share of conscious sensation or voluntary motion, chiefly in order to show how independent these functions may be of the intellect and will with which they are frequently combined in ourselves.

The best terms to apply in discussing this difficult subject seem to be: *impression* for the effect of a mechanical or other "irritant" or "stimulus" upon a living organism; *sensation* for the change which is propagated from the impressed part; and conscious sensation or *perception* for the mental change in an intelligent creature. A beam of light if it reaches a healthy retina produces an impression, a normal optic nerve conducts a sensation to the brain, and a conscious brain receives it as perception.

Notice that the only criterion we have of sensation is from resulting movement. We know, each one in ourselves, that a beam of light has made an impression upon the eye, that we perceive colors and form, and this phenomenon is apparently not followed by movement. But we also know that if we look at another person's eye, when a bright light falls upon it, there has, unconsciously to him, a movement taken place, the muscle of the iris contract, and the pupil changes in size. Here, then, sensation is followed by movement, which is as certain and as automatic as the movement of the amaba or sensitive, and the strongest will cannot prevent the movement of the pupil. You can produce at will—dilatation, or contraction of the iris—either by the direct stimulus of light, or by the still more wonderful action of drugs, the man, to whom the pupil belongs, acting solely as a machine, obeying the action of calabar beam or of atropia, without any will on his part. It is true there are other forms of sensation which do not, as far as we know, produce any motion; as, for instance, the sense of smell which ends in a certain mental effect, of which we do not know the physical conditions. For the present, however, I ask you to put this part of the subject on one side. So far as we can follow motion and sensation, rigidly, and exactly, that is, in the same definite and scientific manner, in which you follow the reactions of a salt in a laboratory, so far we find the same sequence carried out that we found in the mimoia, the Dionæa, and the amœba. Sensation is followed by movement, and it seems probable the advance of physiology will show the prevalence of this law in a larger and larger circle; that we shall discover that no impression, whether heat, or cold, or smell can occur in a healthy organism without calling forth some corresponding change, some movement which is the appropriate result of the stimulus. This, however, is speculation. For the present let us go back to the simple and most elementary form of nerve and muscle, and centre, of which I draw this rough diagram. Here is the end of the afferent nerve which receives the impression, here the line along which sensation travels to a ganglion cell, here the efferent nerve which carries back the message as a motor stimulus, and here the muscular fibre which completes the circle by its contraction.

But though this apparatus is the usual and characteristic sensori-motor organ in man, I must remind you that we cannot always, even in this most perfected animal organism, distinguish these several parts. We find in all animals, man included, organs which are complete sensori-motor machines in themselves, including reception, central and discharging element just as we have found them in the amaba and the sensitive plant.

You all know that the interior of the trachea is covered with minute masses of nucleated protoplasm, of more or less conical shape, and that each of these little bodies is covered at its free extremity with a fringe of fine hairs like eye-lashes. You have seen the movement of these cilia under the microscope in the cells lining the frog's mouth. You can stimulate them, you can retard or stop them. But though thus under control, this is not a mere mechanical movement, because if you leave them alone after a time they die, the cell becomes a dead cell, and no stimulus can excite movement. When the cilia have become languid, you may give them an artificial stimulus, if you add a drop of weak alkaline solution; but the movements produced last for a shorter time, and then cease; you may revive them a second time, but at last no further stimulus is of any use, the cell is then dead. What we recognise as life in man is present in each of these little cells, each has its own life, can be affected by surrounding circumatances, can be poisoned, or stifled, or destroyed by mechanical injury. So that you see the movement of these cells is exactly correspondent to the movement of our own body. Yet no research has yet shown anything approaching to a muscular or nervous structure in these ciliated epithelial cells.

Again, the spermatozoa of all animals have the power of contraction. They are so small that hundreds of them are packed together in one single secreting cell, and yet each one has this power of spontaneous movement. For a third example, for which we need not go beyond ourselves, we may take the cells we find in the blood. The white corpuscles have this power of movement, which can be seen by warming the drop of blood so as to stimulate them. They will move very much in the same way as the amaba, throw out processes, and change their shape. They have even the power of squeezing themselves through the vessels, and so passing out into the tissues beyond, and they may pass out in such numbers as to be visible to the naked eye, and we call the mass an abscess; and if you put under the microscope one of these leucocytes it would be impossible to say whether it was a white corpuscle of the blood, or whether it was an amœba taken from the pond. The functions and the structure, so far as our means go, are precisely the same in both cases.

In these three instances, present in our own bodies, of leucocytes, spermatozoa, and ciliated epithelium, we have examples of movements without any muscle and without any nerve. You may ask what is the stimulus which produces these movement. Of that we have no knowledge, but there can be no doubt that they do contract

in obedience to a stimulus; and for this reason—that we can modify, quicken, or stop the movement. When the stimulus ceases to act, they die, and become incapable of movement. There is therefore no doubt that the movements of these three cells follow the same law as the movements of the sensitive plant, or of the amaba. The fact remains, that when we can trace it, we always find a stimulus is followed by a corresponding movement. In the higher organs the process becomes more and more difficult to follow, and we find more and more complications, until we no longer trace this remarkable correllation between stimulus and movement. Here we arrive at the unknown region, and here physiology stops—for the present. Its task is to investigate the several functions of our bodies, by help of the laws of mechanics, light, heat, and electricity, and by equally demonstrable and exact vital laws. So long as we can do so we must be content to leave on one side the more complicated, the more inscrutable functions of the nervous system, ideas, thoughts, emotions, they do not come under physiology, but under psychology, a science which has hitherto worked by totally different methods.

I will now show you an experiment which illustrates the fundamental characters of all sensori-motor functions. Here are the two fore legs of a frog which has just been killed, with the segment of the thorax to which they are attached. They form the apparatus of which I have just drawn a diagram: an afferent nerve, a centre, an efferent nerve and a muscle. And the apparatus is alive. As far as will and consciousness make life, the frog is (we may assume) dead. But even in man the tissues continue alive after the brain has ceased to think, and the heart to beat, and in a cold-blooded animal they maintain their vitality for a longer time. Any sensation produced here will be unperceived, any motion will be involuntary. I now pinch one foot; this irritant produces an impression on the living nerve; the impression is conducted as a sensation to the ganglion cells of the segment of spinal cord, and reflected as a motor impulse down the efferent nerve till it reaches the muscle, and there it becomes a stimulus to the living muscle and has caused it to contract. The series of translations of force is now complete, for it was the muscular contraction of my hand which supplied the stimulus to the afferent nerve. I now destroy the cord by passing a probe through the vertebral canal, and you see that, the chain being broken, stimulus to one foot produces no movement in the other. But so long as the apparatus is complete and living motion follows sensation, as surely as the movement of the hands of a clock follows the falling of its weights.

MEDICAL WARDS.

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The following cases were admitted from March 5, to March 11, 1874.

PHILIP

1—Diabetes
2—Albuminuria
3—Pleuro-pneumonia
28—Sciatica (?)
41—Aortic Disease

JOHN (Clinical)

1—Gall Stones

MIRIAM (Clinical)

No admission

STEPHEN.

26—Tæna Solium
27—Sciatica
36—Phthisis
43—Epileptiform Attacks

MARY

5—Morbus Cordis
10—Bronchitis

ADDISON.

1—Chorea
36—Sacro-iliac Abscess ?

ASTLEY COOPER

9—Hemiplegia
18—Chorea
17—Chlorosis
21—Cerebral
22—Hæmoptysis

SURGICAL WARDS.

—o—

The following cases were admitted from March 5, to March 11, 1874.

ACCIDENT

1—Lacerated Wound of Neck
7—Compound Fracture of Leg
10—Fractured Fibula
11—Compound Fracture of Leg
12—Fractured Tibia
13—Compound Fracture of Right Tibia—Simple Fracture of Left Tibia
16—Fractured Thigh
18—Concussion (slight)
23—Contused Hip
24—Lacerated Wound of Leg
25—Left Forearm Torn Off—(Amputation)—Right Hand Cut Off
27—Fractured Tibia and Fibula
32—Fractured Tibia and Fibula

CORNELIUS

1—Incised Wound of Forearm

LYDIA

2—Femoral Hernia—Operation—Sac not Opened
4—Disease of Knee-joint
5—Compound Fracture of Radius and Ulna
10—Carcinoma Mammæ
13—Hæmorrhage after Operation on Breast
18—Impacted Fracture of Neck of Femur
20—Femoral Hernia—Operation—Sac not Opened

MARTHA

18—Hip-joint Disease—Functional

NAAMAN

No Admission

LAZARUS

No Admission

LUKE

18—Hæmorrhoids

JOB.

15—Disease of Elbow-joint
20—Scrotal Hernia (reduced)
28—Fractured Femur with Knee-joint Complication

DORCAS

No Admission

CHARITY

4—Disease of Ankle-joint

RUTH (Ophthalmic)

33—Staphaloma
44—Corneo Iritis
48—Cataract

BARNABAS (Ophthalmic)

11—Granulations and Panus
15—Cataract
16—Cataract
17—Staphaloma

PHYSICAL SOCIETY.

The tenth meeting of the session was held on Saturday evening last, when Mr. W. H. Jones read a paper on "Jaundice," of which the following is an abstract :—

He commenced his paper by passing in review the secreting function of the liver and the properties of the several constituents of the bile, referring to the artificial conversion of the bile acid into the bile pigment, and the probable identity of hæmaturia with bili rubin ; also the occurrence of the several constituents in other parts of the body—cholesterine having been found in the blood, while the acids and pigments have not been discovered there. The theories brought forward in explanation of the presence of bile pigment in the blood, staining the tissues and urine were next dealt with. Obstruction had long been acknowledged as one cause of the phenomena but cases often occurred in which this condition could not be detected. To explain these Budd and Harley had suggested that suppression of the secretion occurred and hence the materials of the bile accumulated in the blood. Frerichs attacked the theory, avering that the acids and pigments were formed by the liver, but suggested that non-obstructive jaundice was due to non-consumption of bile acid (a small quantity of which normally entered the blood and was passed off by the kidneys after transformation in the lungs) and consequent formation of bile pigment. Kühne stated that bile acid was not thus convertible into pigment, but that if glycocholic acid were injected into the veins of an animal pigment was formed owing to the action of the acid on the hæmatin of the blood corpuscles. Mr. Jones considered that Frerichs' theory was less borne out by facts than Kuhne's, provided the latter's analyses of urine be correct. The symptoms of icterus were next dealt with. Xanthopsy was referred to as rare, and a case of it was mentioned. The order in which the pigmentations occur was indicated both in internal and external organs. Death might occur through the kidneys or the liver, or from exhaustion. The means of diagnosing jaundice by the conjunctivæ and the urine were considered, and the fallacies connected with these signs pointed out. After enumerating the causes of jaundice, and showing how they were supposed to act, the conditions of the various parts and secretions in icterus from these causes were indicated in so far as they affected the diagnosis. The test for bile acid in the urine was considered by the essayist to be useless and fallacious. In conclusion the treatment was dwelt upon. In chronic obstructive the three indications were—1st, to counteract the evils arising from absence of bile from the intestine ; 2nd, to purify the blood ; 3rd, to attend to any anæmia, dropsy, and emaciation that may supervene.

Mr. LAMB opened the discussion by congratulating Mr. Jones on his able paper. He agreed with him in his division of the causes of jaundice into obstructive and non-obstruction, and thought the diagnosis between them very essential but often difficult ; cases said to be due to suppression were probably often really caused by pressure on the smaller ducts. Itching was, he thought, caused by the accumulation of the biliary acids. The degree of yellowness of the skin did not mark the severity of the disease.

Mr. FRY mentioned a case of jaundice in Mary Ward, where the yellow tint had changed in a few months to a dirty brown. Mr. Durham passing through the ward, had remarked that in his experience such a peculiar colour of the skin was indicative of disease of the pancreas. In two cases of jaundice accompanied by excessive itching, Dr. Moxon had given codcia with marked relief. Physiology taught us that bile acted as a natural purgative, but Dr. Wilks had often pointed out that constipation was not by any means always present.

Mr. DAY made a few general remarks about jaundice.

Mr. C. REES thought the cases Mr. Jones had mentioned in which at was found in the stools pointed to jaundice being due to disease of the pancreas. With regard to the case in Mary, Dr. Wilks had that day said he suspected there was disease of the pancreas. He mentioned the case of a gentleman who, after any anxiety, was subject to diarrhœa usually followed by jaundice.

Mr. DRING also thought it right to divide the causes of jaundice into obstructive and non-obstructive. He had lately seen a case attended with exophthalmos, and would like to know if there was any connection between the two ?

Mr. PYE-SMITH said he fancied the colour of the skin in the case previously mentioned was due to the length of the disease. He had seen three or four cases of xanthelasma occurring in protracted jaundice. He had found great difficulties in testing, if patients ever did see yellow ; but blotting paper stained with bile seem to be a good means of testing. Post-mortem he had seen the lens and viteous stained yellow,

Mr. Ashby thought Mr. Jones had given a very interesting sketch of the physiology of the liver. It was a subject full of interest, but disappointing on account of the numerous conflicting theories and experiments. There had long existed a controversy between chemists and physiologists as to the existence of biliary acids in the urine. The test was the more difficult from its depending on a single color. A lecturer at a London Hospital had told him he could always get the blue color in biliary urine. Mr. Ashby tested and found normal urine gave almost the same color. He had almost come to the conclusion that there was but one form of jaundice : that due to obstruction, and he thought the swelling of the liver cells in acute atrophy would account for the jaundice which occurred. He had only seen one case in which the patient saw yellow and she could distinguish the different shades of that color.

Dr. TURNER agreed with Mr. Ashby as to the cause of jaundice. In many cases it was impossible to say when the obstruction existed, but because it could not be found it did not follow that none existed. Some one had mentioned diarrhœa being caused by mental emotion; this was probably the result of altered function.

Mr. ROUTH thought the reason Mr. Jones did not find bile in the blood in one of his cases, might be due to its having been taken from the veins of the chylo-poietic viscera, *i.e.*, before the blood had passed through the liver.

Mr. SHADWELL said that in the case of complete suppression there would be no jaundice, this was shown by some experiments made by Browne-Séquard, who removed frogs' livers and kept them alive for for some time.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country

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Guy's Hospital Gazette.

VOL. III.—NO. 25. SATURDAY, MARCH 21, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE

DR. ADDISON.

A volume just published by Dr. Lonsdale, entitled "The Worthies of Cumberland," contains a biography of the late celebrated Physician of Guy's Hospital. Although Addison was personally unknown to the present race of students, his name is perpetually ringing in their ears; they hear it pronounced with reverence by their teachers, they hear it familiarly as giving a title to a ward; his striking features they see in the marble bust in the Museum, and the preparations, drawings and models in the same place, must leave upon them some impress of his mind. His spirit, indeed, is still pervading the school of Guy's, and therefore any particulars of his history cannot but be of interest to us all.

Some of the quotations which we shall give, will convey to our readers the striking features of Addison's fine character, and may be read with profit and instruction by all. The allusion to his association with Bateman, the celebrated dermatologist, will explain to our modern student the reason why Addison took a special interest in skin diseases, and the reason of his laying the foundation of the world-famed collection of wax models in connection with our distinguished artist, Mr. Towne. It will be obvious why we have followed the nomenclature of Willan and Bateman up to a late period, but this is now being revised in the new catalogue, compiled by the present curator of the Museum, Dr. Fagge.

Dr. Lonsdale writes—

At noon, on Thursday, the 5th July, 1860, the venerable priory of Lanercost received within its hallowed enclosure the mortal remains of a great physician—one of Nature's true aristocracy. Without the show of pageantry, and under the branches of an ancient yew, by the side of his uncle, Dr. Samuel Addison, the obsequies of Dr. Thomas Addison were performed in the presence of a few friends, the mode and place of interment being alike accordant with the wishes and character of the departed. Lanercost Priory has a time-honoured history of seven and a half centuries. Within its precincts the warrior knight, the lordly abbot, and yeoman bold of times gone by, sleep their last sleep; but from the days of Robert de Vallibus, the founder, through the stirring period of "Bolted Will Howard," down to our own day, no truer man in science and honour and practical usefulness lies there enshrined than Thomas Addison, M.D.

Dr. Thomas Addison sprang from the rank of the yeomanry of Cumberland—men who cultivated their own acres, and practised the economy and thrift common to their order, and thereby enjoyed an honest independence. His forefathers resided at "The Banks," in the parish of Lanercost. Joseph Addison, the father of Thomas, was brought up to farming pursuits, but had an interest in a trade at Longbenton, near Newcastle: thither his mother, having gone in company with her husband, gave birth to the hero of this memoir, April, 1793. By the accident of his birth he was a Northumbrian, though no one can call in question his Cumberland blood and origin.

Those who have sought to claim in the Physician of Guy's Hospital a son of canny Newcastle, will, it is to be hoped, rest satisfied with this explanation of his Cumbrian descent, and it may strengthen their belief to know that Dr. Addison always looked upon, The Banks, as his home. He repaired thither for his holidays every autumn, and under the ancient roof tree of his Commonwealth ancestors, assembled his guests on his marriage day. Moreover, he used to express a hope that his last resting-place would be among his kinsmen under the shade of the old yew tree, at the north-eastern boundary of Lanercost Churchyard.

Thomas Addison received his chief education at the

Grammar School of Newcastle-on-Tyne, and there acquired such a masterly knowledge of Latin that he was enabled to take notes of the lectures of the Edinburgh professors in that language, and also to speak and write it fluently. He took his degree of Doctor of Medicine, 1815, selecting for his inaugural thesis, "De Syphilide et Hydrargyro."

Dr. Addison chose London for his field of practice, his first residence being Skinner Street. Seeking for a public appointment he became connected with the Lock Hospital, where he acquired a practical knowledge of a subject which had engaged his thoughts at Edinburgh. Moving to Hatton Garden, he became one of the medical officers of the General Dispensary, and for some time studied skin diseases under the celebrated Dr. Bateman, and with such marked care and success, that not a few of his professional brethren were disposed to invest him with the mantle that fell from Bateman's shoulders.

For a second time Addison appeared to miss his mark in life. He had thrown aside the opportunity that a special study of sexual diseases afforded him, and after acquiring great proffciency in skin affections, made no more account of them than any ordinary physician. Both fame and fortune were to be had from either of the walks he had abandoned. With Addison the investigation of any disease meant the full exercise of his abilities till he had mastered it, and having done this he could not rest till he broke up fresh ground for tillage. No one was better fitted to extend our knowledge of skin diseases, and to realise the reward of success, so that his withdrawal from their more direct cultivation betrayed a want of worldly wisdom. An innate hostility to anything bordering on a "speciality in medicine" seems to have possessed him, possibly from the fear of falling into a groove of quackery which he abhored, or as probably due to the comprehensiveness of his mind, that would not tolerate a stilted or narrowed walk in a profession of such amplitude as Medicine.

Those who had the benefit of listening to Addison discussing the general status of his profession in England, and the various paths pursued in the metropolis by men more anxious for pecuniary results than scientific reputation could not fail to see the direct and honourable aims guiding his opinions. In antipodal attitude to all that pertained to exclusiveness of thought, he looked at special forms of disease not as phenomena to be treated *per se*, but as portions of the entire science embraced under the term "General Medicine." He always held that if you wished to be a good physician you must know the constitutional form of morbid action incident to Surgery, and on the other hand a safe practice of surgery beyond the operative art required a large knowledge of medicine proper.

To be continued.

LECTURES ON MEDICINE.

BY DR. WILKS.

DISEASES OF THE RESPIRATORY ORGANS.

PHYSICAL EXAMINATION OF THE CHEST.

(*Continued.*)

Auscultation.—An explanation of the sounds heard by applying the ear to the chest is far more easy than that of the percussion sounds; indeed, I believe, if a novice were to apply his ear to the lungs in various states of disease he might at once infer what the physical conditions were within the chest which produced them, such as the rattling of bubbles, the hollow sound of a cavity, the meaning of negative signs in pleuritic effusion, &c. I shall merely describe to you the most important auscultatory signs, and those which it is necessary for you to retain in your memories; you can afterwards learn the subject more fully either in practice or from your books.

First, as regards the natural sounds. If you place your ear near the trachea you will be aware that the air is passing in and out of a large tube, and if you place your ear over the shoulders you will have the same in a lesser degree. This is called *tracheal* and *bronchial* breathing. If, now, you place your ear over any part of the chest you hear the ordinary breath sound or *respiratory murmur*. This has been likened to various familiar noises—as the rushing of the air through the foliage of a thick forest, or the murmuring of the waves on the sea-shore, but I think no closer resemblance to it can be found than that which is produced by gently blowing through the lips. This breath sound is one and continuous. In ordinary quiet respirations it is heard only with inspiration. In forced breathing a sound may be heard at the commencement of expiration, but if so it is added on to the inspiratory sound so as to be one and continuous with it. As the chest falls, as a rule, no sound is heard; if there be any expiratory sound audible, it is abnormal and signifies disease. Much controversy has taken place as to the seat and cause of the respiratory murmur. It is clearly not due simply to the exit and entrance of air, seeing that the cells of the lung do not take in and expel air at every respiration, it has therefore been thought due to the propagation of sound carried down from the larynx; but then, again, experiments on animals by opening the windpipe have disproved this. If due to the impingement of air upon any part of the air passages, the seat of this must be in the ramifications of the smaller bronchial tubes: but it may be caused simply by the unfolding of the lung as the diffusion of gases takes place.

As regards the modification of the breath sound. You may remember that it may be altogether *deficient*, showing consolidated lung or compressed lung. It may be *exaggerated* owing to a portion of a lung doing increased work to compensate for a deficiency in another part. This exaggerated breathing is called also *supplemental* or *puerile*, because it resembles the loud breathing heard in the lungs of children. Besides exaggeration and actual deficiency it may be altered in rymth, and a sound be heard with expiration as well as inspiration; also, owing to a deposit in the lung, as occurs in an early tubercular disease of the apex, the respiration may be *jerking* or sacadé.

Now, as regards the *stethoscope*. You must not be led to believe that this is an instrument whose use is to be cultivated by practice, like a violin, for it is merely a handy method of applying the ear to the chest. There are many physicians who prefer their naked ear to the stethoscope, and there are occasions when it is preferable. I think by the naked ear laid on the chest we may obtain a more general idea of the condition of the lungs, whilst by means of the stethoscope we circumscribe and locate the sound. I need not tell you that it is not an instrument framed to intensify sounds or render others audible, which would not otherwise have been perceived, and yet sometimes I should think, from the observations of students about learning the

use of the stethoscope, they had some notions of this kind. You have to hear certain sounds with your ear, or by means of the stethoscope, and then interpret them. I shall not, therefore, waste your time in displaying before you a hundred varieties of stethoscope and dilate on the advantages of each; but give you some general idea of the instrument, and relate to you the history of its invention. You will then see the principle of its construction. Laennec says, "In 1816 I was consulted by a young woman labouring under general symptoms of diseased heart, and in whose case percussion and the application of the hand were of little avail, on account of the great degree of fatness. The other method—percussion—just mentioned being rendered inadmissible by the age and size of the patient, I happened to recollect a simple and well-known fact in acoustics, and fancied at the same time that it might be turned to some use on the present occasion. The fact I allude to is the augmented impression of sound when conveyed through certain solid bodies, as when we hear the scratch of a pin at one end of a piece of wood on applying our ear to the other. Immediately on this suggestion I rolled a piece of paper into a kind of cylinder, and applied one end of it to the region of the heart and the other to my ear, and was not a little surprised and pleased to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than ever I had been able to do by the immediate application of the ear." "I forthwith commenced a series of experiments at the Hospital, Necker, which have been continued to the present time. The first instrument which I used was a cylinder of paper, formed of three quires, compactly rolled together, and kept in shape by paste. The longitudinal aperture, which is always left in the centre of paper thus rolled, led accidentally in my hands to an important discovery. This aperture is essential to the exploration of the voice. A cylinder without any aperture is best for the exploration of the heart; the same kind of instrument will, indeed, suffice for the respiration and rattle, but both these are more distinctly perceived by means of a cylinder which is perforated throughout, and excavated into somewhat of a funnel shape, at one of its extremities, to the depth of an inch and a half." "In consequence of various experiments I now employ a cylinder of wood an inch and a half in diameter and a foot long, perforated longitudinally by a bore three lines wide, and hollowed out into a funnel shape to the depth of an inch and a half at one of its extremities. It is divided into two portions, partly for the convenience of carriage, and partly to permit its being used of half the usual length. The instrument in this form—that is, with the funnel-shaped extremity—is used in exploring the respiration and rattle; when applied to the exploration of the heart and voice, it is converted into a simple tube with thick sides by inserting into its excavated extremity a stopper or plug traversed by a small aperture, and accurately adjusted to the excavation. This instrument I have denominated the *stethoscope*."

You will see these original instruments in the studies of manyold practitioners. By fashioning its sides and enlarging the ear-piece and trumpet-end the present stethoscope has been evolved. Laennec was mistaken in supposing that the central aperture was necessary for the perfection of the instrument, for many medical men carry solid stethoscopes, showing that it is the solid wall which conveys the vibration of sound. The conduction is probably facilitated by the central perforation.

Now, begining with the abnormal sounds, we will first take the air passages and divide them into the *larger tubes*, the smaller or *capillary tubes*, and the *air cells* or alveoli. Now, as regards the larger tubes and the abnormal sounds produced therein, I will ask you to remember the three pounds given by Laennec, as these are the most important. He observed that when mucous was contained in the tubes, as in bronchitis, and the air passed through it, bubbles were produced, and he recognised these as the same sounds which are often heard during the moments of dying or the so-called death-rattles; he, therefore, called this sound "*rale muqueux*," or, technically, rhonchus. He then, also, observed that in bronchitis there might be other sounds when the disease was passing off, or in cases where the disease was chronic. These snoring and whistling sounds, he called the one "*rale sonore*," and the other "*rale sibilant*." The former is heard in the larger tubes, more especially during expiration, and is a low-pitched grave note, whilst the latter is heard mostly with inspiration in the smaller tubes, and is a high-pitched note. These may sometimes be accompanied by a fremitus felt by the hand.

Next we come to the *smaller tubes*, which are affected in capillary bronchitis. The air passing through the mucus during inspiration and expiration, produces a double rale; it is evident to the ear that the bubbles are much smaller than those produced in the larger tubes and that a larger number are heard in a given space. If this should be at the usual seat of capillary bronchitis, at the lower part of the lungs, the diagnostic significance of this rhonchus, cannot be mistaken: since the sound produced in the air cells is called a crepitant rale, this one produced in the capillary tubes is designated the *subcrepitant rale*. Remember the sound is very fine and a double one.

The *crepitant rale* or *fine crepitation* is the sound heard in pneumonia. The crackling is very minute, so that a great deal of it is heard under a very small space of the stethoscope. There is no better similitude than that usually given of rubbing together of a lock of hair near the ear. It is a simple continuous sound, and in this way it is distinguished from the subcrepitant rale before mentioned. It has not positively been decided in what manner the sound is produced, the same questions and difficulties existing as in the case of the natural respiratory murmur. As air does not directly enter the alveoli of the lungs and again immediately escape, so the sound cannot be caused by the simple passage of air; but just as the natural sound is probably caused by the unfolding of the healthy lung, so is the crepitation in pneumonia produced, in the same manner when viscid secretion is present. This would, of course, replace the natural breath sound by a crackling.

PHYSIOLOGY OF MOTION AND SENSATION.

BY DR. PYE-SMITH.

LECTURE II.

You remember the experiment I showed you at the end of last lecture and the diagram of the several parts of the sensori-motor apparatus there seen in action when reduced to its simplest form. I set it going by the mechanical

impression which acted as an irritation or stimulus to the end of the afferent nerve. This was transmitted as a sensitive impulse to the nervous centre, and thence reflected as a motor impulse along the efferent nerve to the muscle, where it ended as a contraction, which exerts a definite mechanical force capable of being measured and applied like any other.

Is this the only way in which a muscle can contract? Here is a prepartion like the first, instead of pinching one foot I touch the spinal cord with this wire and you see a contraction ensues. The stimulus to the muscle then may be direct and central instead of reflex and peripheral. Once more, I remove the limb from the spinal cord and irritate the efferent nerve itself, thus by pinching, or thus by sending an interrupted galvanic current through a short segment of it. You see movements of the limb are again produced. Lastly, the question arises, can we make a muscle contract by any other means than a nervous impulse? Is its irritability, or excitability independent of or dependent on its connection with a motor nerve? I have here a frog's fresh gastrocnemius muscle, which I have cut away from its nerves, and on placing the electrodes on it as I did on the nerve, the electric shock produces a distinct contraction. But you will fairly object that there are still living nerves inthe muscle, and so I may really have stimulated its fibres not directly but through these. The proofs that muscle may be made to contract by direct stimulation are: (1) that in some parts *e.g.*, the lower part of this sartorius in the frog, no nerve fibres can be traced; (2) various conditions (an "ascending" electric current, and urari poisoning, as I shall afterwards show you), suspend the "irritability" of nerves, and we can still stimulate their muscles, while ammonia, which does not excite a nervous current, does produce a muscular contraction; (3) if I strike this gartrocnemius with a probe, you see a slight contraction over the whole muscle, but, presently a more steady contraction of the part struck, and the transverse "wheal" thus formed does not correspond with any nervous distribution.

It is not unlikely that some of the painful contractions of parts of muscles which we feel as "cramps" may be *idio muscular*, and so may even be the slight vibrations you will often see in the pectoralis when you percuss a phthiscal chest, but almost every muscular contraction we know of in health and disease is excited from the central organs, either primarily or as the result of an impression on the distal extremity of an afferent nerve.

We may compare this simplest form of the sensori-motor apparatus to a telegraphic system. The end of the sensitive nerve corresponds to the receiving office, the nerve itself to the wire, the central organ to the head office, and the end of the motor nerve to a second country office. A man in Norwich who wishes to send a message to a correspondent in Bristol, passes an electric current through an isolated "up-wire" to London, it is there read off and a second current is made to pass along a "down-wire" to Bristol. There the electric force is transmuted into mechanical movement and the disc which spells out the message answers to the contracting muscle. This is the usual way of correspondence, but you may go direct to the head office in London and send your "efferent" message thence, or you may "tap" the down-wire between London and Bristol, and by chemical, magnetic or other stimuli send an electric current to the distal end of the wire. Lastly, it is possible to make the Bristol disc spell out a message, by moving it directly, without using electricity at all: but practically this is seldom or never done.

We may now ask what is the process in the muscle which produces movement? and I must first remind you of the structure concerned. You know that every muscle is surrounded by a sheath of fibrous tissue, known as the *fascia propria*, and that in cleaning a muscle you find processes (*septa*) which divide it into bundles (*fasciculi*) of fibres. (Or a small muscle may consist of only a single fasciculus.) On cutting across a fasiculus, we find, as you see in this diagram, that the fibres which compose it are again separated (or held together) by a finer, denser, and more vascular connective tissue called the *perimysium*. Last, we come to the primitive or ultimate muscle fibre. This is a long, soft, reddish structure, about $\frac{1}{400}$ of an inch broad, circular or sometimes angular in section, and marked with its characteristic transverse lines (*striæ*). By processes which we have performed in the practical course of histology, we find that each fibre is closely inverted by a perfectly transparent, structureless skin (*sarcolemma*), beset with oval nuclei, which contains the soft red stuff within, much as the gut contains the meat of a sausage. This soft stuff within consists of a multitude of regularly arranged short rods (*sarcous elements* of Bowman, or *muscle prisms* of *Kühne*), which after death may separate transversingly, so as to form discs, or, more frequently, lengthwise, so as to form fibrilæ; just as a regiment of soldiers in close order, may divide into ranks or into files. (The presence of a kind of cement uniting these prisms as mortar binds bricks into a column, and other points of the minute anatomy of a muscle fibre, are still disputed or have not received a physiological interpretation). Beside these fibres and connective tissue, there is more or less fat between the fibres; blood-vessels, which form long oblong meshes within the fasciculi; lymph vessels (comparatively scanty); and nerves. Separating as much as possible these structures, which may be called the *stroma* of a muscle, we find that its proper or peculiar substance, (*parenchyma*), which forms the fibres, yields chemically an albuminoid compound called *myosin*, which coaguates after death, and water containing the following compounds in solution:—(1) Salts, especially potash salts; (2) pigment, probably identical with that of the blood, hæmoglobin; (3) albumin; (4) creatin; (5) glycogen and other carbo-hydrates; (6) acids, probably lactic, and lastly, gases, especially carbonic acid.

THE CHAMELEON.—M. Paul Bert has undertaken a very nteresting series of researches on the mechanism of the changes of the colour of the chameleon. They depend entirely on the action of the nervous system; by exciting emotions of fear, passion, avivity, he produced changes from black to yellow, blue, violet, and rose-colour, in very short space of time. These changes were not affected by arresting the blood-supply to a limb, but were immediately stopped in any part by dividing the nerve which supplies it. The complete independence of the two eyes (which is very observable in watching the chameleon), was tested by suddenly awakening it by a light held before one eye, when the corresponding side of the body immediately changed colour, each side of the body assuming another tint when it awoke in turn. The two luminous preceptions were different, and the difference of coloration shows the difference of the impression on the nerve of sense.—*Medical Record.*

Dr. Andrew Dodson.

It is with deep regret that we announce the death of one who, though he spent but a short time among us, rapidly gained the esteem of those whose fortune it was to know him, and won for himself and his hospital a position so high that his name had become familiar to all. Andrew Dodson came to us from Birmingham, where he had previously greatly distinguished himself by gaining numerous prizes, both at Queen's College and the General Hospital. He entered at Guy's in October, 1872, and true to the teachings of his first college, which from time to time has sent us some of our most diligent students, he soon made himself known as an earnest worker in the wards. In 1873 he was admitted a Member of the Royal College of Surgeons and Licentiate of the Apothecaries Society; in November of the same year he passed his final M.B. Examination at the University of London, and obtained first-class honours in two subjects, being placed third in both Medicine and Midwifery. Subsequently Dr. Dodson was elected House-Surgeon to the Children's Hospital at Birmingham, and whilst assiduously carrying out his duties there, he fell ill from what appeared at first to be but a slight cold, the symptoms, however, suddenly increased, and he died from acute tuberculosis on February 15th, after an illness of only eight or nine days. The professors of the college and staff of the hospital, together with upwards of one hundred students, formed a procession, which followed his remains to the great Western Railway Station, whence they were conveyed to his home at Wellington. We know well how much larger that sombre procession would have been, had not distance prevented the students of this hospital from joining to do honour to his memory.

FOOTBALL CLUB.

GUY'S II. V. MERCHANT TAYLORS' SCHOOL.

This match was played at Blackheath on Saturday last, and ended in our defeat by one goal and two touches against two tries and two touches. Merchant Taylors' won the toss and elected to play against the wind for the first half-hour. The ball being started, we kept it well up in our adversaries' quarters, and in a short time Smart, by a good run, obtained our first touch-down, but the Guy's man in bringing it out, dropped it on the ground and a scrimmage ensued, the try being thus lost to us. Merchant Taylors' now, by some good forward play, carried the ball into the middle of the ground, but it was soon returned by a good run from Breach, and we soon compelled them to touch it down twice in succession just before half-time, Reader following up a kick from one of the forwards, dribbled the ball past the Merchant Taylors' backs and obtained a second try, but the try by Poland did not result in a goal. The ball being again started, we compelled Merchant Taylors' to touch it down again, half-time was almost directly afterwards called. Merchant Taylors', with the wind in their favor, soon began to pass us, chiefly owing to the loose play of our forwards, some of whom thought it their duty to watch the game instead of taking part in it, After compelling us to touch the ball down twice, one of our opponents' half-backs ran in with the ball and touched it down almost behind our goal post, the try being well converted into a goal by Luke. Nothing more was seored till time was called, although we kept the ball well in our opponents' quarters.

For the School, Wells, J. Shearman, Goldberg, and Taylor played well, whilst Breach, Mutch, Smart, and Wallis were most conspicuous for Guy's.

Teams, Guy's :—Backs—J. H. Poland (captain) and Breach; half-backs—Smart and Mutch; forwards—Wallis, Perry, Reader, James, J. Polland, Richards, Mainwaring, Mansell, Chapman, and Steel. Merchant Taylors :—Half-backs—Wells (captain) and J. Shearman; backs—Metcalfe and C. Luke; forwards—Cave, M. Shearman, Brooke, Goldberg, Gordon, Purves, Loppitt, F. Luke, Despard, and Taylor.

GUY'S I. v. CLAPHAM ROVERS.

On Saturday, the 14th inst., the Guy's 1st Fifteen played their final match for the present season against the Clapham Rovers. The game was a very good one, being closely contested throughout, and ended in a draw in favour of Guy's. During the first five minutes the Rovers scored a touchdown, but after this the Guy's men played up so well that, while nothing further could be obtained by their opponents, they were able to score four touchdowns and two touches in goal, and in addition very nearly obtained a goal, Power making a fine drop from a fair catch, the ball dropping about a yard short of the cross-bar. All the Guy's men played up well, but we must not omit to mention Breach, who made two very good runs, and both times narrowly missed getting in. The following formed the Guy's team :—Forwards—Bonsor (captain), Gibb, Brown, Welchman, H. Duke, Wallis, Mutch, Breach, Gilbert, and Wilkinson; half-backs—Finch and Maclean; three-quarter back—Gray; backs—Power and Pearson.

MEDICAL WARDS.

The fotlowing cases were admitted from Feb. 12 to Feb. 18, 1874.

MIRIAM (Clinical)

22—Peritonitis
24—Albuminuria
29—Pentonitis

JOHN (Clinical)

3—Locomotor Ataxy
9—Pleuro-pneumonia

STEPHEN.

9—Syphitis Lardaceous Disease
16—Syphitis Lardaceous Disease
19—Bronchiectasis
85—Phthisis
48—Morbus Cordis

MARY

9—Hydatid of Liver
18—Bronchitis

ADDISON.

27—Double Moveable Kidney
34—Phthisis

SURGICAL WARDS.

—o—

The following Cases were admitted from Feb. to Feb. 18, 1874.

ACCIDENT

5—Intoxicated
5—Fractured Tibia and Fibula

CORNELIUS

3—Injury to Head and Fractured Clavicle
4—Compound Fracture of Humerus
6—Injury to Head
7—Fractured Tibia and Fibula
9—Fractured Tibla aRd Fibula
10—Concussion
11—Pott's Fraeture
12—Kick from a Horse in Abdomen
17—Fractured Pateila
19—Smashed Great Toe

LYDIA.

No Admissions

MARTHA

3—Carcinoma of Breast
18—Carcinoma of Breast
19—Ulcered Leg

JOB.

No Admissions

LAZARUS

2—Necrosis of Tibia (re-admission)
11—Irritable Bladder
18—Fistula in Ano

LUKE

No Admissions

NAAMAN

2—Diaeased Ankle
5—Incarcerated Hernia
7—Internal Piles
9—Epistaxis
10—Femoral Hernia—Operation—Death
11—Carcinoma Penis

DORCAS

3—Ulcerating Hæmorrhoids
3½-Necrosis of Femur
4—Tumour on Back—Operation
6—Chancre on Lower Lip
7—Malformation

CHARITY

No Admissions

STUDENTS' BIBLE CLASS.—The last meeting for the Winter Session will be held on Tuesday next, March 24th, at Hibernia Chambers, London Bridge, commencing at 6.30 p.m, Subject—John xvi. 16-33

MR. ALFRED HOOPER has been appointed House-Surgeon to the Infirmary, Burton-on-Trent.

IT is stated that Miss Elizabeth Morgan, M.D., one of the physicians of the Hospital for Women, Marylebone, is about to follow the example of her colleague, Mrs. Anderson, M.D., by entering into the bonds of matrimony. Her future husband is a physician.

A REMEDY FOR TOOTH-ACHE.—"Having spent a number of years of my professional life in the country, where no dentist was near, and therefore being often called to prescribe for tooth-ache, I tried many combinations of drugs, and many published formulas, with more or less satisfactioa to myself and patients. But several years since I hit upon the following combination, which I have found better than any I have ever used, and it will give reiief in almost all cases where such a remedy is applicable :—Take of carbolic acid, saturated solution ; hydrate of chloral, saturated solution; camphorated tincture of opium ; fluid extract of aconite, of each an ounce ; oil of peppermint, half an ounce. Mix. Apply by saturating a pledget of cotton (or preferably a smsll piece of sponge) and pack closely into the cavity of the decayed tooth."—Dr. Q. C. Smith, Cloverdale, in *Medical Record*.

RECEIVED—The London Medical Record,—The Medical Press and Circular,—The Students' Journal,—The Aberdeen Medical Student—The Country

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Guy's Hospital, S.E.

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All communications for insertion must be written on one side of the paper only, with a space in the left hand margin. The name of the Writer in full must accompany each communication.

Gentlemen will greatly oblige by giving us notice of any news about the Hospital, which may come to their knowledge.

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Guy's Hospital Gazette.

VOL. III.—NO. 26. SATURDAY, MARCH 28, 1874. 13 Nos. Free by Post, 2s. 6d. TWOPENCE

DR. ADDISON.

(*Concluded.*)

(From Dr. Lonsdale's "Worthies of Cumberland.")

Dr. Addison was appointed Assistant Physician to Guy's Hospital in the year 1824, and soon afterwards became lecturer on Materia Medica. He was soon marked out as the "man of Guy's" upon whose shoulders the future fame of the institution would very much rest. After ten years' service as lecturer on Materia Medica he was appointed Physician to Guy's Hospital, and at the same time selected as the colleague of Dr. Richard Bright in the duties of the Chair of Medicine. His co-operation with Dr. Bright was more visibly brought out by their joint editorship of a practical work, "Elements of the Practice of Medicine," the greater part of which was written by Addison.

He read to the Physical Society of Guy's several papers on pneumonia and phthisis, in which essays he maintained "that inflammation constitutes the great instrument of destruction in every form of phthisis." These views were so irreconcilable with current opinions that the profession in England were tardy in adopting them, yet they came to be recognised by continental physicians, and Niemeyer seems to have fairly established Addison's claims as an original and accurate observer.

Dr. Addison deserved high place among the chief men of his times, whilst in the capacity of physician he stood second to none of his order in an age unusually prolific of men of true eminence. In personality, be it feature or type that shows character, he was imposing and grand. No one could mistake the lofty bearing of the man and his gentlemanly demeanour, exalted by a natural self-esteem yet guarded pride.

> Active and nervous was his gait; his limbs
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He looked a man at all points—nay, character was manifest in every inch of his make. Perfect in build, of commanding presence and firm significant step, he possessed a keen penetrativeness—indeed, a special discernment that never failed him in private life, and but rarely at the bed-side of the sick. He stood before you the impersonation of power and dignity and independence. The bust of Addison in the Pathological Museum of Guy's Hospital shows every feature well-defined, comporting well with his finely-proportioned massive head. He had dark hair, large eye-brows, and eyes of deep hazel colour; his nose was pronounced, his lips full and voluble and rather special in action, and his chin firm and broad, and his general physiognomy stamped with vigour and unmistakable character throughout. A more devoted son of Esculapius than Addison could not be met with in these latter days of progressive England. He was of the type of Boerhaave, Sydenham and Hunter, examples of the best of their order in the past of medical history. As a lecturer and teacher of practical medicine, he probably had no rival in Britain, and in personal knowledge of some extent it may be questioned much if any of his contemporaries on the Continent surpassed him in that notably special work.

The facility with which Dr. Addison read disease on the countenance of his patients was striking to behold; he seemed to possess the diving-rod, so great was his intuitive vision of the workings of human action—one day all medical London rang with the news that Addison had made *another* extraordinary diagnosis. The affection, new to the

world, was soon traced, both at home and abroad, and the French physicians, headed by Trousseau, named it after its discoverer, *La Maladie d'Addison* (Morbus Addisoni), and doubtless as long as Medicine has a history the description of Addison's disease will be found recorded in its pages.

Guy's Hospital had long had a deservedly high reputation, to which Sir Astley Cooper, Dr. Bright, and others lent additional lustre, but some are of opinion that Addison, single-handed, raised a higher column than any of his predecessors of the present century. He was admitted to be one of the most impressive teachers and assuredly popular amongst the students, many of whom were attracted to Guy's on his account alone. He raised the tone of the hospital in various ways, not less by his own indefatigable will and superior sagacity than by his infusing into the young minds around him a noble professional ardour. His mode of instruction was well fitted to develope the latent worth of the aspiring student, and his example could not fail to reproach the idle and apathetic to be found in every great school of medicine. How many men, coming under the immediate eye of Addison rose to distinction and frankly owned their success in professional life to his guidance. Great in himself he strove to make others great, and hailed with pleasure the introduction of fresh blood into the hospital, hoping thereby to see the wave of fame rising higher and higher with the increasing years in its history as a medical school.

Addison did not attain the position in the metropolis that was really due to his transcendent merits as a physician and man of honour. He was highly esteemed by his colleagues, and almost idolised by the students of Guy's Hospital, and these were amongst the most gratifying circumstances in his medical career. If he obtained neither Court preferment, nor all that he deserved at the hands of his countrymen, he reaped honours abroad, where partiality could only arise from a full knowledge of his merits as an original observer and discoverer. Being called on to make a professional visit to one of the Rothschild family, he met with the most cordial acknowledgements of the great men of the French capital. MM. Troasseau, Nelaton, and all the *élite* of the profession attended a public dinner in his honour, and the exalted opinion entertained of Addison as a medical discoverer was enhanced by the force and eloquence of his reply to "the toast of the evening," which he spoke in admirable French. So spontaneous and hearty a reception as Addison met with at the hands of his French contemporaries has seldom if ever been accorded to any English physician.

In the winter session of 1859-60 his health began to fail, when a letter of condolence was addressed to him by his pupils, the reply to which will be found in the Sydenham Society's edition of Addison's works. He died on the 29th June, 1860, æt. 68 years, and his remains taken to Lanercost, as already described. On the western wall of the abbey is a tablet erected by his widow, on which it says that "he was, during thirty-seven years, Physician and Lecturer at Guy's Hopital, the duties of which position he performed in a manner to secure to himself eminence in his profession, and the gratitude of his numerous pupils. To his talents and industry that school is mainly indebted for the celebrity it has attained." A marble tablet in the Chapel of Guy's Hospital sets forth in a few eloquent words the eminent talents of Addison, and Dr. Lonsdale ends his biography by relating how Addison, a few months before his death, when near his country home, gazed over the distant scene of Lanercost Priory, with meadows around, the ancient city of Carlisle, and the Solway in the distance. The setting sun shone gloriously, lighting up the beauties of the scene. Addison looked upon it with intense delight, and as if prophetically impressed with its being the *Omega* of his home joys, exclaimed "What can be more heavenly than this!"

THE ATHLETIC CLUB.

ANNUAL MEETING.

The annual meeting of this club was held on Wednesday last, in the Anatomical Theatre, to audit the accounts, elect a secretary and committee, and other matters.

There was a full attendance of members, and Mr. Hicks was unanimously voted to the chair.

The Chairman, after a few introductory remarks, called on Mr. Wells for a statement of the accounts.

Mr. Wells said he was extremely sorry to inform those present that there was only a small balance in hand, viz., £4 10s., which was accounted for by the fact of the members having had sports of their own, and which had involved an expenditure of £31 16s. 3d. more than last year. He then read the accounts, and thanked the committee for their co-operation during the past year, and hoped that the meeting was satisfied that he had done his utmost for the good of the club, and resigned the post of secretary.

It was proposed and seconded, and carried unanimously, that Mr. Wells be re-elected as secretary.

The following gentlemen were then elected to form the committee :—Messrs. Power, Robson, Hicks, Gibb, Elliot, Tyson, E. Duke, J. Mackern, Gilbert, Maltby, Reader, and Gray.

It was then arranged that the club should hold sports of its own, but that the prizes should not cost so much as last year.

Votes of thanks were unanimously presented to Mr. Wells, for the able manner in which he had conducted the business during the year ; also to Mr. Hicks, for presiding over the meeting.

The following were the receipts and expenditure of the past year :—

Balance from 1872 ..	..	£19	16 6
Subscriptions, &c. ..	..	59	16 9
Total Receipts ..	..	£79	13 3
Expenditure	..	75	3 3
Leaving a Balance of ..	...	£4	10 0

PHYSICAL SOCIETY.

—o—

The last meeting of the Session was held Saturday, March 21st. Mr. Cock, the Honorary President, was in the chair, and Mr. Clarke read a paper on "The ratio between the pulse and respiration in disease.

There were present, the Treasurer; Dr. F. Taylor and Mr. Lucas, hon. secs.; Mr. Howse, late hon. sec.; Messrs. Pye-Smith, Hicks, F. C. Turner, T. D. Ransford, W. H. Harsant, H. Ashby, J. P. Bevan, and F. T. Paul, presidents; and about one hundred members.

The minutes of the preceding meeting having been read and confirmed, the Chairman called upon Mr. Clarke to read his paper.

Mr. A. H. Jones congratulated Mr. Clarke upon the very able manner in which he had handled his subject; he considered that several points had been brought forward which were both interesting and new. He especially noticed that Mr. Clarke had observed the fact that the ratio was lowered in rheumatism for two or three days before the occurrence of any cardiac complication; and also that by variation in the ratio hæmorrhage and other complications of typhoid might be anticipated. Mr. Jones then made some remarks upon the differences in the pulse-respiration ratio in health depending upon position of the patient, time, &c., observing that this might be a source of fallacy. But since he had made no original observations in this direction, he was unwilling to take up more time which could be better occupied by those who had.

Mr. Pye-Smith considered the subject a most difficult one to speak on, consisting as it did, of *facts*. If he threw doubt on the ratios given as the most frequent (and he should have thought 4 to 1 by no means above the average), it simply showed that he was ignorant of the facts; on the other hand, if he admitted that Mr. Clarke's figures were correct, who would believe that he had made sufficient observations to know? Having had the advantage of reading the paper previously, he had looked up a case of relapsing fever that he had reported some years ago, and found that the fall in the pulse-respiration ratio had preceded that of the temperature by one day. He thought that the fact that so terrible a disease as typhoid and fatal cases of typhus gave a raised ratio coincided with one's general impression of the unfavourable significance of a constantly rapid pulse.

Mr. Harsant thought Mr. Clarke was certainly to be congratulated upon the amount of labour he had spent upon his paper. The mathematical skill shown in it was very considerable. But it seemed to him to have been much ado about nothing, for even if he had proved his theory, that there was a standard ratio in health which varied in a certain direction with each disease, we had much better aids to diagnosis, and this could be well dispensed with, even in typhus and typhoid, in which Mr. Clarke had especially pressed its value. And he would venture to remark that we might occupy our time better that by observing Mr Clarke's recommendation to continue with these researches.

Mr Hicks hoped some one would stick up for Mr Clarke. He thought it a very noble thing to write an original paper, and if Mr Harsant was a better man than Mr Clarke, why did he not make some original observations? He thought the paper a very able one, and one that might very likely help him in solving some knotty point.

Mr Fry was very pleased with Mr Clarke's paper, but he regretted that time had not permitted him to go into chest diseases, since these were the only cases in which he had interested himself in the ratio. He narrated a case in which the ratio was very peculiar.

Mr Tyson thought it useless to attempt to draw conclusions from any individual case, since Mr Clarke had analysed the statistics of the last three years. But this doubt had occurred to him—were the observations of the pulse and respiration upon which Mr. Clarke relied correct? He was bound to admit that he would have been more exact had he known that his cases would have been used for such a purpose, and if they were not correrct of course Mr, Clarke's conclusions were worth nothing.

The Chairman remarked that the writer of the paper ought to know best whether the observations were correct.

Mr. C. Rees thought that even supposing Mr. Clarke's conclusions to be incorrect, still much good would have been done by leading up to other and correct conclusions. He could not agree with the opinions expressed by Mr. Harsant, for we could not have too many aids to diagnosis. He believed the normal ratio to be higher than that given by Mr. Clarke.

Mr. Chicken remarked that he remembered Sir William Gull in the last lecture he had delivered at the hospital, saying, "I consider that nothing is beneath the dignity of a physician which conduces to the recovery of his patient." He thought the remark applicable in the present instance, for he considered that nothing was unworthy of attention which conduced to the scientific advancement of our profession. He thought Mr. Clarke had opened a new field for operations, which, if persued, would lead to good results, as an additional aid of diagnosis. Mr Fry lamented the absence of its application to diseases of the chest, and he (Mr Chicken) thought that considering the ability and ingenuity with which he had already explained one complicated case of thoracic disease by its means, the future investigation of the subject could not rest in better hands than his. He trusted the society next winter would hear an elaboration of the subject from the hands of Mr Fry.

Mr. Richards expressed his concurrence with the opinions of those speakers who condemned Mr. Harsant's speech. Mr. Clarke had only claimed for his paper the humble position of a symptom, and as such it was certainly of value. He could not agree with Mr. Tyson as to the incorrectness of the ward clerk's observations of pulse and respiration, for he presumed that all could count.

Mr. McKern was sorry that Mr. Clarke had left out nervous diseases, since the action of nerves on the heart must considerably affect the ratio.

Mr. Lamb congratulated Mr. Clarke on his valuable additions to the life history of various diseases, and thought that time spent in collecting such data for medical sciences was not wasted; but he could not see of what practical value the "pulses respiration ratio" could be in diagnosis, as single observations are so liable to vary according to the emotions of the patient; if he has the slightest suspicion that the respiration is being counted, the frequency is at once diminished, and the mean ratio of a number of observations cannot be obtained until the disease has terminated favourably or otherwise.

The Chairman then called upon Mr Clarke to answer the remarks made upon his papers, and then proceeded to the important business of the meeting, by calling upon Dr. Taylor for the presidents' decisions as regards the prizes offered by the society.

Dr. Taylor informed the members that the Presidents had divided the prizes of £10 and £5, for the two best papers read before the society, equally between Messrs. Clarke and Lamb. That they had awarded the prize of £5 for the best essay sent in during the session to Mr Clarke, for his essay on "Some Points in the Morbid Histology of Cirrhosis of the Liver," with an additional sum of £5 in recognition of its unusual excellence; and that they had awarded the speaker's prize to Mr. Lamb.

The Chairman expressed great pleasure in congratulating the prizemen: he would do so in as few words as possible, since anything more that he could add would be completely put into the shade by the hearty cheers of their fellow-students.

Mr. Ashby—Mr. President and Gentlemen,—It is my pleasing duty to-night to congratulate those gentlemen who have won prizes on their success. They have both obtained double honours. We, who have had the privilege of reading Mr. Clarke's paper on "Some Points connected with Cirrhosis," as you have already heard, have a very high opinion indeed of its merits. He has spent a long time and great care in its preparation, and has made observations of great value which are in some respects new. It is accompanied by drawings, the minute exactness and skill of which rival those in a neighbouring establishment. And when the paper comes before the public you will agree with us in envying the diligence and skill of its author. You have already passed judgment on the paper we have heard to-night, and all have joined in praising the labour and care bestowed on its preparation. By careful accumulation of facts, he has shown us what I was not prepared to hear, that given normal lungs, normal heart, and integral nerve centres, and tracts in certain diseases confined to the blood, the pulse-respiration ratio varies in an almost constant manner. He has also drawn our attention forcibly to the altered ratio as indicating at an early period cardiac or pneumonic comple tion. Doubtless much of the practical value of his deductions depend upon the amount of variation from undetermined cases, which exist in a state of health. But whatever be the fate of his observations, we all join in admiring his working powers, and heartily encouraging his further investigations. Mr Lamb's admirable paper on "Temperature in Disease" is still fresh in your memory, and the important points he brought so prominently out are not forgotten. No more useful guide to diagnosis and prognosis of disease is found in the whole realm of practical medicine. I have to congratulate him, too, on a prize obtained for his talking powers, and trust that in years yet to be, he will look back with pride on this early recognition of his genius by Guy's Physical Society in 1874. In conclusion, gentlemen, in your name, I heartily congratulate the winners of the prizes.

Mr. Clarke said it was with no ordinary pleasure he rose to thank them for the double honour they had done him that evening. Ever since he had joined the Physical Society—now three year ago—it had been his earnest wish to obtain some memento of one of the most valuable institution connected with the hospital. The efforts induced by that wish had that evening born fruit far beyond his expectation or his deserts, and although he could not but feel that there were other members who must have sent in papers of equal, if not superior, merit, he know there were none who would look back upon that evening with greater pleasure, and treasure the award with greater pride than he should.

Mr. Lamb briefly acknowledged the congratulations of the chairman and presidents, and hoped that the society would always be in as flourishing a condition as it had been, and of considerable benefit to future students.

Mr Chicken said that he was sure what he was about to propose would be very welcome to the members of the society, viz., a vote of thanks to the Treasurer of the hospital, to whom each member was indebted to for the privileges enjoyed at the hospital, and for the use of the theatre in which the Physical Society assembled. Mr Chicken said he felt sure that all the members, like himself, were glad that the Treasurer had come among them that they might have the opportunity of thanking him personally not only for his kindness to them individually as students of the Hospital, but collectively as members of this society.

The Treasurer in acknowledging the vote of thanks, remarked that he had often been formally thanked by the society at these meetings, but really neither the Govenors nor himself had ever done much for it, not for lack of interest in the society, but because the means at their disposal whereby they could assist it were very slight. They could only supply the room and other such necessities, its welfare being entirely in the hands of the students, and the gas-light supplied by the Govenors would be of no benefit to the society without the intellectual light of its members.

Mr. Lamb, in proposing a vote of thanks to the presidents, remarked that it afforded him great pleasure to do so, as the success of the Society was in a great measure due to their efforts, and he was sure that all those who had been to the meetings during the session, heartily joined him in his motion, as they had opportunities of seeing what an active part the presidents took in the various debates.

Mr. Pye-Smith rose to respond. The position of the presidents was a pleasant one—a self-constituted oligarchy; they, of necessity, were made acquainted with all the discoveries brought before the society, and had the pleasing privilege of awarding the prizes. Yet, even the presidency had its drawbacks, and, not to mention the collection of subscriptions, without which no prizes could be awarded, it was not pleasant to be obliged to ignore the merits of many whose papers or speaking powers came near to those of the prizemen. The session had been characterised not only by the number of excellent papers, but by the liveliness of debate. He could remember when long pauses were the order of the evening, but during this session there had been no lack of speakers. The times to which he referred reminded him that he was now speaking only in virtue of being senior president, and members of the society would readily believe how much regret was mingled with the pleasure he felt in representing the presidents when he knew that it was the last time he should address them from those benches, and not impossibly the last time he would even be an auditor in that theatre. He would conclude by thanking the society for its cordially expressed vote of thanks to the presidents, and by expressing the hope that the places left vacant by the retirement of himself and some of his colleagues would be filled by those—he would not say who would take more interest in the society, that,

he hoped, was impossible—but whose natural endowments would enable them to *show* still more interest in the Guy's Hospital Physical Society.

Mr. Turner—Mr. Chairman and Gentlemen,—The proposal which I have now to make is one which will, I feel sure, meet with your warmest approbation. It is that a vote of thanks be accorded by this society to their honorary secretaries. Nor is there any need to remind you in how great a degree the prosperous condition which the society now enjoys is due to the interest taken by the secretaries in it, and the exertions made by them in its behalf, whether in augmenting the number of its members, or increasing the attendance at its meetings. If the society has to regret the loss of the services of Mr. Howse, who so long and so energetically filled the office of secretary, and who has honoured us with his presence this evening they are to be congratulated on having acquired those of Mr. Lucas, who has shown that he takes a no less active interest in their affairs. To Dr. Taylor we have to express our acknow, ledgments for again undertaking the duties of secretary and for the zeal with which those duties have been discharged. I beg to propose that a most cordial vote of thanks be accorded by the society to their honorary secre taries—Dr. Taylor and Mr. Lucas—for the active interest they so kindly take in its welfare, and for the constancy with which they have favoured its meetiugs with their presence.

Dr. Taylor said—Mr. President and Gentlemen,—I am very grateful to you for the cordial manner in which you have received the vote of thanks proposed by Mr. Turner. I can assure you that both my colleague, Mr. Lucas, and myself, have the greatest interest in the proceedings of the society, and have the greatest pleasure in doing all we can to ensure its success. I have been very pleased to observe the marked progress of the society in the various points touched upon by Mr. Pye Smith. The attendance of members, the number and quality of the speeches, and the supply of papers for discussion, have been, throughout this session, highly satisfactory. It is only on this last matter that I have a word to say. I should like to see issued as early as possible in the session, a complete list of the papers to be read; such an arrangement would greatly assist one of the first objects of the society, namely discussion, for the members of the society having a sufficiently long notice would be enabled to direct their attention to the subject proposed, and would come to the meeting prepared with material not only for an animated debate, but for a profitable discussion. Only this evening we have had an instance of the converse, when even one of our senior members states that he is not familiar enough with the facts recorded by the reader of the paper to confirm or deny his conclusions. It has often been somewhat difficult to obtain a paper, and I have felt much disappointed if we have had, a few days before the meeting, to ask one of the presidents to fill the gap. I am happy to say that the presidents have been troubled only once this session, when an able paper was read at very short notice. In conclusion, I hope that next year, we, as secretaries, may be able to do in the interests of the Society, as much, if not more, than we have in the past session.

Mr Hetley—Mr Chairman and Gentlemen,—I rise to propose a vote of thanks to our honorary president, Mr Cock, and I am sure no urging on my part will be needed to induce you to respond to such a proposal. I had begun to think, that in my small way I had been connected with this society for a long time, yet I doubt if I have known it as many months as Mr Cock has years. This is one of the rare opportunities we have of hearing Mr Cock, for it is not all of us that can remember him as a clinical teacher in the wards. We not infrequently still see him as a spectator in the operating theatre, and we all value his kindly greeting whenever he meets us. Gentlemen, I beg to propse that a vote of thanks be offered to Mr Cock.

Mr Cock said that he could only thank the members once again for their kind and considerate greeting. The fact became plainer to him year by year that as one gets older one loses many of the old associates, for one finds it very difficult to keep them in repair. He dwelt upon the time he had been connected with Guy's Hospital, he was getting on in life, and had been forced to relinquish his more active duties in the wards, but he clung to anything belonging to Guy's Hospital, especially to the students, with whom he had been connected for fifty years, and if there was any deparment of the school to which he was more attached than another, it was to the Physical Society, which he had watched over since its commencement, and it did his heart good to see its members thriving in zeal and ardour and knowledge, for he could see its good results every time he came, and he shonld see again, as he had often seen before, its members rising to be not only good medical men, but men of world-wide renown.

The meeting then adjourned.

MEDICAL WARDS

—o—

The fotlowing cases were admitted from M arch 19 to March 25, 1874

MIRIAM (Clinical)

Cot—Croup

JOHN (Clinical)

13—Pleuritic Effusion

ADDISON

38—Chorea

MARY

7—Morbus Cordis
8—Pleurisy
13—Inanition
16—Psoriasis (Specific)
21—Congenital Syphilis

STEPHEN

4—Pleuritic Effusion
20—Acute Rheumatism and Morbus Cordis
28—Ichthyosis
34—Morbus Cordis
38—Morbus Brightii
41—Diabetes Mellitus

ASTLEY COOPER

3—Paraplegia

PHILIP

2—Aortic Disease
12—Subacute Gastritis (?)
13—Pneumonia
14—Ulcer of Rectum (?)—Hæmorrhage from Bowel
27—Acute Rheumatism
31—Tumour of Brain
43—Bronchitis—General Anasarca
45—Syphilitic Tumour of Brain
47—Subacute Gastritis

SURGICAL WARDS.

The following cases were admitted from March 19 to March 25, 1874.

ACCIDENT WARD

2—Compound Fracture of Tibia
5—Fracture of Tibia and Fibula
8—Scalp Wound
9—Compound Fracture of Tibia
19—Injury to Abdomen
23—Synovitis
29—Impacted Fracture of Neck of Femur

LAZARUS

4—Poplitæal Aneurism
5—Abcess in Back
8—Sinus in Thigh
10—Epithelioma of Penis
12—Perinæal Abscess
13—Retention of Urine, Cystitis
14—Abscess in Penis

LYDIA

10—Epithelioma in Face
11—Fibroid Bursa Patellæ
12—Nasal Polypi
13—Needle in Hand
24—Abscess in Thigh

MARTHA

1—Supernumerary Thumb
2—Strangulated Femoral Hernia
4—Circumscribed Gangrene Foot
7—Cancer Breast
8—Fractured Tibia and Fibula
9—Injury to Thigh
15—Sloughing Bursa Patellæ
33—Abscess Forearm
1—Cot—Disease of Knee-joint
2—Cot—Injury to Abdomen

JOB.

No Admissions

CORNELIUS

No Admissions

CHARITY

20—Supernumerary Thumb

NAAMAN

2—Cleft Palate
9—Fissure in Rectum
12—Perinæal Fistula
20—Ankylosis of Elbow-joint

DORCAS

5—Necrosis of Ribs
7—Injury to Head
8—Talipes Varus
10—Carotid Aneurism
13—Disease of Knee-joint
21—Disease of Knee-joint

LUKE

4—Suppuration about Knee-joint

MR. HINTON has resigned the office of aural surgeon, and Mr. Purvis has been appointed his successor. Mr. Hinton was the first aurist who has held office at Guy's, and has enjoyed a far-and-wide reputation as an aural surgeon.

APOTHECARIES' HALL.—Mr. Leonard James Wilding, London Road, Worcester, of this Hospital, passed his examination in the Science and Practice of Medicine on the 26th inst., and received his certificate to practice.

NOTICE.

Owing to the length of our special report of the Physical Society, we are obliged to defer the continuation of the Lectures by Dr. Wilks and Dr. Pye-Smith until our next issue.

The next issue of the "Guy's Hospital Gazette" will be on Saturday, April 11, after which it will be continued weekly as before.

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